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An exploration of embedding the community matron role in three settings making the invisible visible?

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An exploration of embedding the community matron role in three settings: *making the invisible visible?*

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A thesis submitted in partial fulfilment of the University's requirements for the Degree of Doctor of Philosophy

Coventry University

Faculty of Health and Life Sciences

Department of Nursing, Midwifery and Healthcare Practice

March 2014

The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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My thesis would not have made it to the submission date without help from so many people. One of the participants in my study talked about a 'jigsaw of care' made up of big and small contributions to the whole. I am applying the same analogy to describe achieving a 'whole' PhD.

So, a lot of thanks are due to people who have helped me.

A natural place to start would be with the participants, without whom, my study would not have got to where it is. You all gave so generously of your time and I appreciate that very much.

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Abstract

Background

The role of community matron (CM) was introduced to provide a single point of access to patients living with co-morbid long-term conditions who had, or were at risk of, frequent emergency admissions to hospital. CMs utilised case management as a means of managing this growing population of patients with fragile health. Since its inception, many changes in service delivery have impacted on the role.

Aim

The aim was to undertake a mixed methodology study of the factors that have affected embedding of the community matron role in 3 geographical areas.

Methodology

A pragmatic mixed methods approach (QUAL quan) was utilised.

Settings and participants

The studies were based in health services within 2 cities and a rural area in central England. Participants for the qualitative components of the study were purposefully sampled. The sample comprised professionals: community matrons (n=21), managers (n=4), former commissioners (n=2) and GPs (n=3); and patients (n=10) and their family carers (n=5). Quantitative data for 212 people with long-term conditions were derived from the anonymised Patients at Risk of Rehospitalisation database (PARR data) held by area 1.

Methods

Qualitative data were collected from participants using semi-structured interviews and audio diaries. For the quantitative component using PARR, some patient journeys within area 1 were explored. In addition, a sample of patients who were case managed by a CM (n=106) were matched with a set of patients who were not (n=106) and the data was examined.

Findings

Participants were largely positive about the role of CM. However, difficulties with role setup had led to numerous changes which affected how the role has embedded. Additionally, this impacted understanding of the role by health care professionals, and caused practical and emotional difficulties for some CMs as they perceived the role to be eroded. The quantitative findings showed that CMs did not make a significant difference to hospital bed days used by patients on their caseload. Evaluating the role and finding an effective means of showing the work undertaken by CMs, which is often invisible, proved difficult.

Conclusion

Embedding of the CM role has been affected by numerous changes in service delivery. Invisibility of community nursing rather than autonomy of the community matron role seems to be a key factor in the challenges of embedding the role. The significance of these findings is that using a mixed method approach and Liaschenko and Fisher's adapted model may help CMs to improve the visibility of their role, and so helping the role to be less prone to the challenges of service redesign.

Original and Significant Contribution

Original and significant contribution to research

This study is the first to take use a mixed methodology to examine, across different sites and service contexts, the process of embedding of the role of community matron to undertake case management with people with long term conditions.

The thesis has built on the work of a number of authors who have examined invisibility in nursing. Where it is unique is in considering these factors in community settings and in the work nurses do across the boundaries of the community setting and the hospital setting. While other studies of the work of community matrons have focused on outcome measures such as cost effectiveness and reduction in hospitalisation, this is the first study to apply the lens of invisibility in nursing to the work of community matrons. Using this lens may allow nurses to connect health policy and service designs to the needs of people to whom they deliver nursing. As such, my thesis adds a new perspective to a historical nursing argument of invisibility, as well as further highlighting that an autonomous nursing role is no more likely to be embedded.

Dissemination

Aspects of this research have been presented at this conference:

Randall, S. Managing Individuals with Co-morbid Long-term Conditions, using a Case Management Approach by Community Matrons in an English Inner City.

Positioning Nursing for the Future: Advancing Nurses' Roles in Community and Healthcare.
National University of Singapore / National University Hospital International Conference 17-19,
Nov 2011 (2nd prize: oral presentation)

This research has informed the writing of the following peer reviewed publications and book chapter:

Randall, S., Daly, G., Thunhurst, C., Mills, N., Guest, D. and Barker, A. (2014) Case management of individuals with long-term conditions by community matrons. *Primary Health Care and Research* 15, (01), 26-37

Randall, S. (2011) 'Care Coordination' in *Long-term Conditions. A Guide for Nurses and Healthcare Professionals*. Ed. Randall, S. and Ford, H. Chichester: Wiley Blackwell 221-262

Thunhurst C., and **Randall S.** (2010) Applied Research: building the evidence base for health sector development. *International Journal of Therapy and Rehabilitation*. 17 (8), 344-351

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Glossary of Terms and Abbreviations

Applied Research at Coventry University, a broad definition is used: 'Applied in nature and based on excellence in discipline-based research, pedagogical research, or knowledge transfer including CPD activity'.

Advanced Nursing Practice 'A registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master's degree is recommended for entry level' (International Council of Nurses 2001)

Boundary work is work undertaken by nurses which may be deemed outside the remit of nursing or healthcare but is in response to patient and/or carer need. This boundary may overlap with other areas of professional care such as social care.

Care coordination is the deliberate organisation of patient care activities between 2 or more participants in a patient's care to facilitate the appropriate delivery of health care services. Organising care involves the marshalling of personnel and other resources needed to carry out all the required patient care activities and is often managed by the exchange of information among parties responsible for different aspects of care. (Agency for Healthcare Research and Quality [AHRQ] 2007:v)

Community matron (CM) is a nurse who provides advanced clinical nursing care in addition to case management (as defined above) to an identified group of very high intensity users through case finding (NHS Modernisation Agency & Skills for Health, 2005). In my study community matrons are case managing individuals with long-term conditions.

District nurse(s) (DN) is frequently used as an umbrella term and is often loosely applied to describe many types of nurses working in the community. However, in this research study 'district nurse' relates to registered nurses who work as part of a community / district nursing team

Case Management is defined as ‘the process of planning coordinating, managing and reviewing the care of an individual (Hutt et al. 2004). It should be considered in line with the domains of case management shown in section 1.16

Chronic Diseases can be defined as diseases of long duration that generally progress very slowly. Chronic diseases, such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes, are by far the leading cause of mortality in the world, representing 63% of all deaths (DOH,2005).

Clinical Commissioning Groups (CCGs) Clinical commissioning groups are groups of GPs that will, from April 2013, be responsible for designing local health services In England. They will do this by commissioning or buying health and care services.

Clinical Commissioning Groups will work with patients and healthcare professionals and in partnership with local communities and local authorities. On their governing body, Groups will have, in addition to GPs, a least one registered nurse and a doctor who is a secondary care specialist. Groups will have boundaries that will not normally cross those of local authorities.

Commissioners (former) The main role of commissioners is to commission (buy) services to meet the health care needs of a local community. The process involves assessing health need, designing services, buying services from a provider and monitoring delivery of services. Their work is undertaken collaboratively. The role has changed following the Health and Social Care Act 2012 and the introduction of clinical commissioning groups.

Community care comprises help available to persons living in their own homes, rather than services provided in residential institutions. In the context of this study it largely refers to care given by community matrons and district nurses.

Embedding the processes through which a practice or practices become, (or do not become) routinely incorporated in everyday work of individuals and groups (May et al. 2009). In this study, how much community matrons are an integral part of the health delivery system

Emergency admission (EA) to hospital is one that is not predicted and happens at a short notice because of perceived clinical need (Purdy, 2010).

General Practitioner (GP) A medical practitioner who works in primary care and is usually the first point of contact for patients who are seen either in a surgery or less frequently at home. They have a broad knowledge base in physical and psychological illness and make referrals to specialist services based on patient need.

Healthcare professionals (HCP) is a generic term for professionals who work in the healthcare sector and includes nurses, doctors, allied healthcare professionals and pharmacists

Integrated team (IT) is a service that takes a person-centred approach in seeking to meet a person's medical, physical, social and emotional needs. A new approach to delivering accessible, responsive integrated community healthcare (Lyndon 2007, Masterson 2007)

Invisibility of nursing is work which is undertaken by nurses, but is difficult to articulate or record and therefore may be invisible to fellow nurses, other healthcare professionals, but is rarely invisible to patients and carers. This may make such work undervalued.

Long-term condition (LTC) A condition of prolonged duration that may affect any aspect of the person's life. Symptoms may come and go. Usually there is no cure, but there are often things that can be done to maintain and improve quality of life (Wilson 1999).

Medical Model refers to the conception of disease established in the late nineteenth and twentieth centuries, based on an anatomo-pathological view of the individual body (Bury 2004)

Policy an overall plan which embraces general goals and procedures and is intended to guide and determine present and future decisions. In this thesis, policy is considered at governmental level, as well as organisational level. A distinction to this effect has been offered each time policy is mentioned in this work

Primary care refers to services provided by GP practices, dental practices, community pharmacies and high street optometrists. About 90% of people's contact with the NHS is with these services.

Secondary care is defined as a service provided by medical specialists who generally do not have first contact with patients. Secondary care is usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Self-management refers to an individual's ability to manage symptoms, treatment, physical and psychosocial consequences and lifestyle changes inherent in living with a long-term condition...to maintain a satisfactory quality of life (Barlow 2001)

Virtual wards (VW) use the systems and staffing of a hospital ward, but without the physical building: they provide preventative care for people in their own homes. (Lewis 2007)

Visibility of nursing work undertaken by nurses that is seen and understood by others including fellow nurses, healthcare professionals and patients

Additional abbreviations

CHCT Community Healthcare Trust(s)

COPD Chronic Obstructive Pulmonary Disease

CNS Clinical Nurse Specialist

DH Department of Health

HES Hospital Episode Statistics

HF Heart Failure

LSOA Lower super output areas

NHS National Health Service

NICE National Institute for Health and Clinical Excellence

NSF(s) National Service Framework(s)

OECD Organisation for Economic Co-operation and Development

PARR Patients at Risk of Re-admission

PCT(s) Primary Care Trust(s)

PFI Privately Funded Initiative

QNI Queens Nursing Institute

QOF Quality and Outcomes Framework

SHA Strategic Health Authority

UK United Kingdom

US (A) United States (of America)

WHO World Health Organisation

WSD Whole Systems Demonstrator

Style Notes

- Reference style is Coventry University Harvard.
- Within my work, I have adopted a direct writing style using personal pronouns. I investigated the literature to justify my decision and this can be found in section 2.4

Chapter 1: Introduction

In my doctoral study, I have examined changes which have taken place surrounding the role of community matron, which was introduced to use case management as a means of effectively managing the growing number of individuals with co-morbid long-term conditions. In particular, I have sought to examine why some aspects of nursing are not as visible as others. This has been done using the example of community matrons who are nurses, rather than other case managers who may have come from another professional health background such as allied health or social work.

My interest in studying the role of community matron came from many directions. In my role as senior lecturer in primary and continuing care and pathway lead for long-term conditions (LTCs) at Coventry University, I often use the role as a means of informing my teaching. Additionally, I have had many community matrons as students in the modules for which I have responsibility. As I have a background in community nursing, this also fosters my enthusiasm. This would probably be a long enough list, but to add further fuel to the fire, so to speak, in 2008 I was part of a team that won two tenders to evaluate community matron services. The first was an evaluation in London. Sadly, the funders did not permit the report to be placed in the public domain, so although it informs some decision making it has not been possible to disseminate the findings. The second evaluation took place in another large city. This forms the bedrock of this study and I refer to it as the parent project. It is discussed in section 5.2 and the executive summary can be found in appendix 2.

As a novice researcher collecting data on the parent project and feeding back to the reference group, I had a growing frustration with the project which sought to examine effectiveness of the community matron service. What mattered most to the report commissioners was that the community matron service had not reduced hospital admissions in a statistically significant way. Qualitative data, which showed how beneficial the service was to patients and their family carers, not least in preventing them going into hospital seemed to be of less importance to the funders. The quality of service delivered and described by the community matrons themselves also appeared of lesser value. The community matrons were most concerned that much of their work was difficult to record

and as I listened to participant accounts I realised that much of their work was not seen and often it occurred at what may be considered the boundaries of nursing/healthcare. My definition of boundary work is offered in the glossary of terms and is discussed in section 7.2.

On venting my frustrations to a colleague and fellow nurse, it was suggested that I explore the work of Joan Liaschenko, an American theorist who has written about these aspects in relation to nursing in the United States (US). This offered me a theoretical underpinning for my thesis (chapter 3).

I have re-examined the original data with emphasis on visibility and boundary work. In addition, I collected data from an additional 2 areas. Further context is provided in section 3.3, alongside the thesis aims and objectives. In areas 2 and 3, service design had different facets than the service in area 1. This allowed me the opportunity to examine the community matron role in light of service changes and to explore how the role of community matron had embedded. By undertaking literature searches on case management and invisibility (chapter 2), there did not appear to be an understanding of why the domains of case management were not sufficient to allow the community matron role to be visible and to embed. Additionally, much of the literature on invisibility is based on nurses who work in teams (hospital or community) and does not consider the autonomous nature of the community matron role. As such, exploring embedding of the community matron role is unique, particularly using the work of Liaschenko as a theoretical lens (chapter 3). Hence, my research question was:

What factors affect embedding of the nursing role of community matron?

The aim was to undertake a mixed methodology study of the factors which have affected embedding of the community matron role in 3 geographical areas.

The following research objectives were formulated:

- To examine how the role of community matron is operationalised through case management
- To consider how the role and service design has been embedded in light of policy initiatives and the emphasis on reduction in admissions to hospital

- To explore aspects of the role and provision of care which are valued by the community matrons, patients and family carers, managers, GPs and former commissioners.
- To examine factors which impact on embedding of the role of community matron from the perspective of the community matrons
- To consider whether using the lens of Liaschenko and her reports of nursing work being invisible help to explore embedding of the current role of community matron

In this chapter, the following sections are presented. Section 1.1 provides background and context of my study and comprises changing demographics, mortality and morbidity; emerging means of managing individuals with long-term conditions (LTCs); current political issues in commissioning; new nursing roles: advanced nurse roles; community matrons and their role, as well as the context in which community matrons were introduced; how the role has been interpreted and how they have been prepared, including education for the role. How nursing roles embed is also examined (section 1.2). It considers the organisational aspects of the NHS and LTC nursing provision in community and primary care settings, as they were influenced by policies at the time.

As noted above, I begin with the background and context of my study.

1.1 Background and context of my study

1.1.1 Changing Demographics, Morbidity and Mortality

In order to understand where the role of community matron originated, it is important to understand the context of changing health patterns.

By the middle of the 20th century, ill health and death as a result of infectious diseases had been overtaken in the western world by chronic diseases (Fitzpatrick 1991). Worldwide, similar trends are reported by the World Health Organisation (WHO 2002). In 2005, the WHO predicted a decline of 3% in deaths between 2005 and 2015 from infectious diseases, maternal and perinatal deaths and those associated with nutritional deficiencies. Over the same time period, deaths from chronic diseases were projected to rise by 17%. These projections suggest that of 64 million deaths in 2015, 41 million worldwide will be as the result of chronic disease (WHO 2005). As such, the WHO (2002) considers that the

management of long-term conditions is the greatest challenge facing health care systems in the 21st century.

More recently in the UK, the term long-term condition has superseded chronic illness/disease as a more positive term. This reflects that individuals have a life to live which encompasses the long-term condition. For many, understanding their disease as it affects them as individuals, being concordant with medications and treatments means they are able to live a full life. In England there are reported to be 15 million people living with a long-term condition (DH 2008a). Again, projections suggest that this figure will rise to 18 million by 2025, linked to the rise in individuals who live to 75 years of age and over. In 2008, the number of over 75s stood at 4.7 million, but this figure will almost double to 8.2 million by 2031 (DH 2008a). Although ageing is closely associated with long-term conditions, in that cells in the body are less able to replicate and thus more prone to the onset of pathophysiology, long-term conditions are not solely the domain of the elderly; 17% of those aged under 40 have a long-term condition. This is in comparison to 60% of over 65s (DH 2008a). In terms of NHS resources, an individual aged over 85 is fourteen times more likely to be admitted to hospital than a 15-39 year old (DH 2008b). Kelleher (2004) reports that the scenario of 'doom and gloom' associated with changing demographics has been challenged by some health economists. Palmer and Short (2000) consider there is substantial uncertainty that an older population will cause a significant rise in demand for healthcare. The importance of promoting health within the ageing population is seen as key and made up an important part of the National Service Framework (NSF) for Older People (DH 2001). In addition, increased prevalence of LTCs is associated with increased exposure to risk factors for further morbidity, such as lifestyle and health behaviours, and as such health promotion is equally important (Rosen et al. 2007).

Further statistics in England show the impact on health services associated with long-term conditions. In 2008, it was reported that the 5% of the population who live with long-term conditions made up 49% of hospital bed usage, although it is not entirely clear whether this statistic only reported bed usage directly associated with their long-term condition. Over 52% of both outpatient appointments and GP appointments were taken by individuals with LTCs (DH 2008a). At first glance these numbers appear to depict a problem, but current thinking in health associated with a 'wellness' perspective, whereby there is a greater

acceptance of personal responsibility for health and a greater understanding of health related behaviours (Stewart 2004), may suggest that these figures actually represent the change in thinking and that individuals with LTCs are working with health care professionals (HCPs) to reduce ill health.

1.12 Emerging means of managing individuals with Long-term Conditions

The general consensus, as noted by the WHO (2002), is that the large rise in individuals with LTCs presents a challenge for health care systems. According to Plesk and Greenhalgh (2001), healthcare comprises a series of systems that are embedded within broader systems and as such policies are developed at macro, meso and micro levels (Randall 2011). Macro level encompasses a broad overview, such as policies around long-term conditions and wider social and environmental policies which emanate from Government Departments; the meso level can be seen as incorporating health care organisations whilst the micro level incorporates *the coal face* where patients, their families and those who deliver care directly to them sit. In the United States, urgent recognition of this issue, because of similar demographic changes, led three of the major health care management organisations to explore effective means of managing individuals with LTCs (Metcalf 2005). The three companies are Pfizer Health Solutions, Evercare and Kaiser Permanente (Evercare 2004, Webb and Howson 2005, Singh and Ham 2006, Rosen et al. 2007). The models designed by these companies have their roots in the Chronic Disease Model which was conceived by Wagner and colleagues in the USA in 1998. By acknowledging that a large proportion of chronic care takes place outside formal health care settings, the principal aim of the Chronic Disease Model (Wagner 1998) is to provide a link between informed, active individuals who have a long-term condition and proactive teams of professionals. It could be suggested that this forms the macro level and the acceptance of a particular working model such as that within Kaiser Permanente (DH 2005a) (shown in figure 1 and described on page 6) becomes the meso level.

One means of managing individuals with LTCs was that of case management for those with co-morbidities and who are at greatest risk of hospitalisation. Pfizer Health Solutions and Evercare concentrated specifically on case management whereas Kaiser formulated a model which integrated care at all levels across the LTC trajectory and additionally included health

promotion of the well population. This model is often represented diagrammatically as a triangle and can be seen in Figure 1.

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Figure 1: Kaiser Permanente Triangle (DH 2005a)

The Evercare model, which is a primary care team model in which nurse practitioners provide intensive primary and preventative care to individuals over the age of 50 with long-term conditions or disabilities in the USA, demonstrated a 50% reduction in admissions to acute facilities, without detriment to health when evaluated (DH 2004a). Further evidence from the USA reports reductions in emergency department visits as a result of community based case management (Poduska 2009). In part because of reported positive results and, in part, because of the similar demographics, the Kaiser triangle and the associated concepts have become important in UK health policy around the organisation of care. In 2005, the Department of Health encompassed the Kaiser model within the Health and Social Care Model (middle column Figure 2) and this became influential in conceptualising the needs of those with LTCs and the idea of prevention (DH 2005a). Integration has been cited as the reason for success of the Kaiser model in the USA, that rather than thinking and working in terms of primary and secondary care as separate entities, individuals with LTCs are seen as the most important and major factor and care is integrated accordingly (Ham 2005a). Community Matrons work at the apex of the triangle with individuals who have co-morbid long-term conditions. Similarly, the role of community matron sits in the top tier of the delivery system within the Health and Social Care Model, ie. case management.

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(DH 2005)

Figure 2: Health and Social Care Model (DH 2005a)

Exploring ideas from the USA and exporting them to the UK may present challenges without due consideration of the vastly different health systems on either side of the North Atlantic. In the UK there is a system of what has been described as socialised medicine where by the state plays a significant role in both the funding and management (Ham 2005b). This is in stark contrast to the United States' system which has multiple funding streams and a market driven system (Ham 2005b). Developments in the USA are as likely to be driven by the interaction of local influences (such as the response of the funders of care to increasing costs, or by physician-led and consumer-led initiatives) as by government policy (Dixon et al. 2004). Current changes in the dominant political ideologies in both countries may see a shift in emphasis with the Obama regime favouring a socialised approach (The Affordable Care Act. US Congress 2010) and the Coalition Government in the UK seemingly favouring a more market approach (DH 2010a).

Additional models were also developed globally (Singh and Ham 2006) to encourage conceptualisation of the issues surrounding increasing numbers of individuals with long-term conditions and the potential impact on healthcare services. One model is the Innovative Care for Chronic Conditions Model developed by the World Health Organisation in 2002. Shown diagrammatically in figure 3, the concept of this model focuses on the

different levels of macro, meso and micro. Although not directly labelled in this manner, the central triangle appears to present the micro view, whilst community and health care organisation offer a meso aspect and finally positive policy environment offers a macro viewpoint. Of particular note in this model is the recognition that consistent financing is a key element within a positive policy environment. Arguably, in the current financial climate, consistent financing is limited within the NHS and as such roles of nurses, for example community matrons, may be less likely to be allowed to embed. However, failure to embed did not start with the financial crisis, but more with a political philosophy which appears to encourage constant change. This will be explored further as this work progresses.

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Figure 3 The Innovative Care Model (WHO 2002)

1.13 Context into which community matrons were placed

During the late 1990s and for most of the first decade of the 21st century, political stability, and indeed financial stability, even investment in England, bought a series of policies which set out a clear strategic focus. This focus was about creating a systematic approach to care for individuals with LTCs which promoted a reduction in the use of hospital care in favour of increasing primary care, and care in the community and home settings (DH 2005a). This is reflected by a paper which shows an increase of 47% in the full time equivalent workforce caring for adult individuals in the community between 1996 and 2006 (Drennan and Davis 2008). A comprehensive review of nurses' contributions to chronic disease management through case management (Goodman et al. 2010) found that policy initiatives in England and Wales between 2000 and 2007 made relatively few references to nurses. Instead, the emphasis appeared to be on health professionals in general and the importance of maintaining a skilled workforce for individuals with long-term conditions, which included the elderly. However, Goodman et al. (2010) reported a greater number of references to specific nursing roles in English policy. These nursing roles were directly linked to reducing hospital admissions and readmissions to hospital and the numbers of bed days spent in hospital as a result of long-term conditions. Of these, one was the role of community matron. Whilst the role was actively rolled out in England, by 2006 the Welsh Assembly Government, having reviewed the evidence and decided it was not robust enough, chose not to implement either case management or the community matron role (Goodman et al. 2010).

The NHS funds and provides most care for people with long-term conditions. At the time community matron services were being implemented, Primary care Trusts (PCTs) were taking the lead on commissioning and purchasing services (Rosen et al. 2007). However, there was a push to further devolve budgets to practices as part of practice based commissioning and the introduction of the GMS contract (Dixon et al. 2004). This introduced specific targets known as the quality and outcome framework which included many LTC issues.

Practice nurses work closely with patients who have LTCs and who are able to attend the GP surgery for appointments, so those who fall into levels 1 and 2 of the Health and Social Care

Model (see figure 1). Drennan and Goodman (2007) describe practice nurses as having some ongoing post registration experience and who often access degree training and short courses in specific LTCs. As CMs cover GP surgeries there is the potential to work together, but often the client groups diverge depending on whether a patient is housebound or not. In 2012, there were 23 458 practice nurses although this only equated to 14 695 FTE (NHS Institute for Health and Social Care [IHSC] 2013).

CMs were introduced into an NHS which had an increasing policy awareness of LTCs (DH 2000a, 2004a). Alongside traditional services such as district nursing, and practice nursing, other services such as intermediate care and fast response had been set up. Intermediate care (IC) teams comprised professionals from physio, OT and nursing. Generally there were 2 models for intermediate care: 'step up' and 'step down'. Step up models aimed to keep people in their own homes during exacerbations by increasing services available to them until their condition stabilised. Some teams had access to residential beds rather than admitting to hospital. This was so in area 1 of my study. Step down models provided intensive services in people's own homes following early discharge thus freeing up hospital beds. Evaluation of IC services found that the desire to move away from IC beds towards greater provision of IC in patient's homes would be associated with lower costs, however results suggested larger short-term gains in both quality of life and functional improvements for patients treated in residential settings (Barton et al. 2006).

Fast response teams were often attached to A&E departments with a view to turning patients around and getting them home rather than into hospital by the use of increased interventions. Such interventions were provided by multi agency and inter disciplinary teams. The latter came to the forefront in policy documents emphasising a better understanding of patient need by providing improved and better integrated delivery by professionals whose team members meet regularly for review and evaluation, thus improving communication and reducing duplication of services (Watson 2001). Area 2 in my study introduced such a service and had the community matrons linked to it. Employment of IC teams tended to be through community health trusts whilst fast response teams were usually employed by acute hospital trusts. The amalgamation of many trusts through Transforming Community Services (DH 2009b) brought services together under one employer. Goodman et al. (2010) describe the human resource and workforce policies at

this time, themed around role redesign, blurring of professional boundaries and increased skill mix.

District nursing (DN) teams continued to offer services to people in their own homes as they had done historically, but were able to access the additional service of IC. DN teams comprised a DN sister (or more than one), community staff nurses and health care assistants. At the time CMs were introduced there was a downward trend in the numbers of DNs (NHS Institute for Health and Social Care [IHSC] 2013, Drennan and Davis 2008). This was exacerbated by the reduction in the number of nurses accessing specialist degree level nursing courses which gave them the title of specialist practitioner. It should be noted that figures offered by IHSC refer to DNs who have specialist practitioner status, but do not take into account recent trends by some higher education providers to educate community nurses to degree and master's level in long-term conditions. This more generic course attracts a broad range of nurses including those working in IC and fast response, as well as allied health professionals (AHP) (on master's courses as they graduate with degrees). This is in line with Goodman et al.'s (2010) notion of boundary blurring. The decline in DN numbers is in sharp contrast to a growth in AHPs of 31.2% since 2002 (IHSC 2013). Some AHPs would have been employed in IC teams, although the term AHP is broader than physiotherapists and occupational therapists and comprises speech and language therapists, dieticians and radiographers to name a few.

The exploration of English policy in this period highlighted that a number of activities were linked with the role of community matron and provide context into which the role of CM evolved. These comprised medical substitution in relation to assessment and prescribing as well as other activities described as supplementing weakness in service delivery systems (Goodman et al. 2010). In addition during this period, there was emphasis on public health (DH 2004b) and actively encouraging individuals to make decisions in favour of healthy lifestyles which may prevent some LTCs or prevent co-morbidities for others. Policies also encouraged responsiveness in health services and urged that a new era of partnership working between patients and health care professionals should replace the paternalistic practices of previous generations of health care practice (Foster et al. 2007).

There is some evidence of change. Fletcher and Mant (2009) found an increase in GP consultations in their study, but arguably developing self-awareness skills in individuals with LTCs may prompt them to find help earlier and is a key aim of LTC policy. A participant in a study by Drennan and Goodman (2011: 23) noted that if aspirations are fulfilled then such service developments may actually increase costs. Shaw and Baker (2004) consider the ideal to be patients who have confidence, knowledge and skills which allow them to play a central role in managing *their* lives. Being well informed has brought some patients into conflict with HCPs (Metcalfe 2005), although Shaw and Baker (2004) consider much of the anxiety amongst HCPs is around imagined perceptions such as patients arriving at the surgery with papers downloaded from the internet on experimental, costly treatments which may not be suitable. The Health Foundation's work around 'co-creating health' (Health Foundation 2008) sought to relieve some of these tensions by introducing courses for HCPs as well as patients. The aim of these courses was for both parties to gain an understanding of the benefits of working together. The effect would be knowledgeable patients and as important, health care professionals who do not feel threatened by their patients' knowledge. As Bodenheimer et al. (2002: 2470) note:

'Professionals are experts about diseases; patients are experts about their own lives'

Arguably, many patients are now equally as knowledgeable as health care professionals about their disease process as well. In effect, working in partnership is about bringing the knowledge held by both parties together in order to meet patient centred goals. Community matrons, through case management, have had this as an important part of their role in working with individuals with long-term conditions.

Services such as that of community matron are commissioned. In the next section of this chapter, I explore the current issues which surround commissioning and how this could impact upon a service.

1.14 Current political issues in commissioning

The political landscape for health looks very different in terms of extensive changes to commissioning as a result of the change in government. Despite this, the white paper: Equity and Excellence- liberating the NHS (DH 2010a) stated that it would build on the Darzi Report (DH 2008a) and continue to focus on patient involvement in care: *'no decision about*

me without me' and self-management as important aspects in the care of individuals with long-term conditions. The role of community matron is less clear within the emerging landscape. With what has been argued as a new period of austerity, the NHS will have a spending reduction equal to about 2% per year 'in real terms' until at least 2014 (Ham 2009). This comes after a period in which the NHS had been relatively well resourced (The Nuffield Trust 2010) resulting in a reduction in length of waiting lists and increased patient satisfaction (National Centre for Social Research 2009). Additionally this saw the UK moving from third to first in a comparison of six countries on a number of criteria undertaken by the Commonwealth Fund (The Nuffield Trust 2010) and with an overall increase in spending on health from 6.6% of gross domestic product in 1996 to 8.8% in 2008 (Organisation for Economic Co-operation and Development (OECD) 2009). Although this appears to be a positive move, the percentage of GDP spent on health within the UK is still less than many other major economies and is perhaps a reason why mortality remains high in the UK when compared against spending on health (The Nuffield Trust 2010). It could also be that other forms of social spending are more important in relation to reducing mortality.

Against the backdrop of financial constraint, GPs are being expected to take over commissioning (DH 2010a). Commissioning is defined by Smith and Thorlby (2010) as:

'The process of assessing the health needs of a population then planning, securing and monitoring the best possible range and quality of health services and health improvement services for that population given the resources available'.(p2)

Previous attempts to give increased powers to GPs and limited commissioning occurred in the 1990s with GP fundholding. Evaluations (Mays et al. 2001) found that although there were improvements in primary care services, initial savings in prescribing and more community based alternatives to hospital care, there was limited ability to move major resources from hospitals to community. Since 2005, practice based commissioning had been introduced. However, Smith and Thorlby (2010) report that this approach to commissioning failed to achieve the hoped for transformation of service delivery. Neither has the expected reduction in hospital beds to more care in community settings occurred, nor was it able to impact on the rising expenditure of the NHS (Smith and Thorlby 2010). One reason which may be considered causal is that 80% of GPs felt they lacked commissioning skills (Kings Fund and NHS Alliance 2009). Ham (2008) reported on a review of commissioning

worldwide and found that no system in Europe, New Zealand or the US did commissioning consistently well; although there were examples of excellent innovation, these were matched with evidence of limitations. In Light's (1998) view, in order to have strong commissioning the following infrastructure is required:

- Excellent data analysis systems
- Programmers
- Organisational managers
- Clinical managers
- Clinical epidemiologists
- Financial specialists
- Legal advisers

The anxiety felt by GPs is understandable as many questions remain (Sawbridge 2011). These include issues surrounding the cost of setting up this infrastructure, what constitutes an appropriate population size for GP commissioning groups, how a fair budget will be negotiated, how patient choice can be maintained and, equally, how engagement will be enhanced with specialists in relation to urgent care and long-term condition management (Smith and Thorlby 2010).

In the US, Ham (2010) reports twenty years of experience in doctor led commissioning for defined groups of patients, but Casalino (2001) notes that where success is evident it has been built on a great number of difficulties and has taken a considerable amount of time. Further evidence for the US points to the importance of strength and longevity of leadership (Thorlby et al. 2011) which, arguably, will require stability in health policy.

In exploring strategies which have been successful in the US in improving service quality and efficiency as a result of the formation of medical groups, it is noted that both skilled nursing led units and nurses acting as case managers are pivotal in reducing hospital admissions in individuals with long-term conditions (Thorlby et al. 2011). Where nursing will sit and how it will be commissioned lacks clarity in the literature emerging in England at the moment. This perhaps detracts from the ideals that the proposed change in health policy direction will actually result in a more integrated and coordinated health delivery system (Ham and Smith 2010). That all the emphasis appears to be on GP commissioning perhaps adds to the fact

that nursing is often overlooked and impact on nursing and nursing roles and thus ultimately patient care is subject to repeated change.

Despite such concerns, this chapter will now move on to explore how new roles have emerged in nursing and, in particular, roles which encompass advancing practice. Following on, both how the role of community matron became established in England and key aspects of the role are considered.

1.15 New nursing roles: advanced nurse roles

The path of nursing significantly changed when registration was introduced in 1919 as a result of the Nurses' Registration Act (Great Britain Parliament 1919 in Abel-Smith 1977: 97). From 1925, state examination was required to gain entry onto the register (Abel-Smith 1977). Shortages of registered nurses dogged the early part of the 20th century culminating in the adoption of a 2 tier system with the introduction of the 'enrolled assistant nurse' (Baly 1995: 173). Throughout this period, the nursing profession has been supported by non-professionally qualified staff. Baly (1995) notes that skill mix has never been static, with auxiliaries making up 23.1% of the workforce in 1937, 16.6% in 1950 and 24.3% in 1962. The introduction of the internal market in the 1980s revisited the question of skill mix (DHSS 1986) as did the introduction of Project 2000, as a result of the move to make nursing students supernumerary (United Kingdom Central Council 1986). The role of health care assistants remains under debate with the Cavendish Review concluding a need for all healthcare assistants to undergo the same basic training, based on the best practice, in order to care for people unsupervised (The Cavendish Review 2013).

Law and Aranda (2010) offer an interesting re-conceptualisation of nursing as shown diagrammatically in figure 4

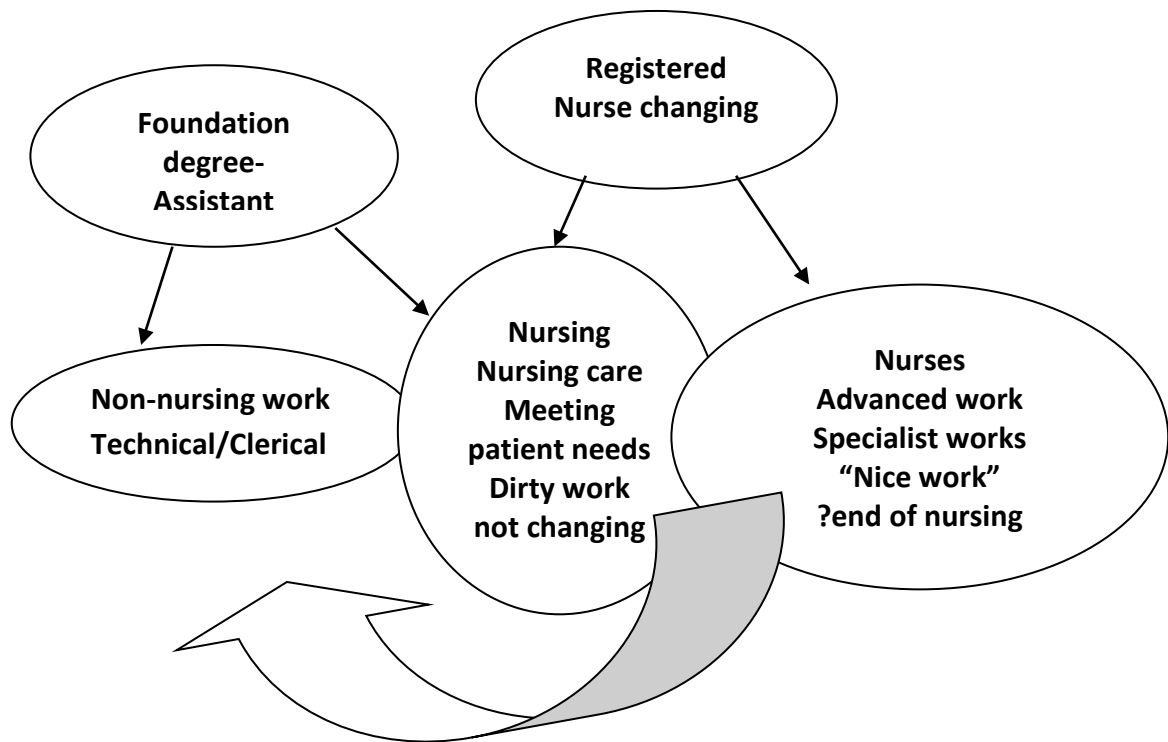


Figure 4: Re-conceptualisation of nursing (adapted from Law and Aranda 2010)

This explores the changes in nursing as a result of the introduction of skill mix, but also shows how nursing roles have changed with contraction at the left of the diagram where assistant practitioners (APs) undertake non nursing and technical/clerical work, but are also seen to be moving into nursing care whilst nursing roles are expanding at the other side into advanced work.

The proliferation of new nursing roles is explored in relation to advanced nursing practice, where the role of community matron sits. The literature examined considers advancing practice as a concept, but also focuses on how effectively new roles are allowed to embed within the English context of health which is dynamic.

In 2001, the International Council of Nurses offered the following definition of advanced nursing practice:

‘A registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master's degree is recommended for entry level’ (International Council of Nurses 2001)

Despite this definition many others exist and, the issue of advanced practice remains contentious. For me, the term advanced nurse practice implies finality, when in fact I would argue that there is always more to learn and as such I prefer the term advancing practice which implies the ability to continue to move nursing forward. Daly and Carnwell (2003) offered a framework in an attempt to distinguish levels of practice. Their distinction explored role extension, role expansion and role development, linking role extension to competent nursing care of an elementary nurse practitioner, role expansion to the role of clinical nurse specialist and role development to an advanced nurse practitioner (Daly and Carnwell 2003). Similar debates have happened in the United States and Australia (Offredy 2000). However, Bryant-Lukosius and Di Censo (2004) note that legislation, regulatory mechanisms and protected titles for clinical nurse specialists and nurse practitioners mean that there is less difficulty in distinguishing roles in the USA.

In the UK, debate continues about regulation of new roles. In 1996 the then United Kingdom Central Council (UKCC) set up a taskforce but decided not to set standards. Re-visiting the question of regulation in 1998 drew the conclusion that regulation was required. However, a change of governing body to the NMC in 2002 delayed any decision. By 2005, a position statement was issued that nurses in advanced positions should have masters level thinking although it stops short of stating that masters level thinking develops as the result of an educational programme at Master's level (NMC 2005a). Instead competencies were drawn up (NMC 2005b). By 2005, the Privy Council was asked to legislate in order to create a new sub part of the register, but without decision despite a further call for the regulation of health care professionals (NMC 2005b). To date, the Council for Healthcare Regulatory Excellence (CHRE) has called for a risk based approach to job titles and that if registers are to be introduced for advanced practitioners then there must be compelling evidence to do so (CHRE 2009).

The complexity associated with terminology is much debated in the literature (Sutton and Smith 1995, Manley 1997, Bryant-Lukosius and Di Censo 2004, Lloyd-Jones 2005). Sutton and Smith (1995) contend that Benner's work on expert nursing practice has complicated the debate, because the work of Benner is well known and accepted. For Benner, expert nursing practice is based on experience built around a specific client group and a specific clinical area and as such there is a familiarity of 'doing' which is strongly linked to practice.

Another commonly used role title is specialist nursing practice, which Sutton and Smith consider makes nurses passive recipients of specialist knowledge from doctors. Additionally, such specialities mirror medical specialities and means influences come from the medical model rather than a nursing model. The medical specialisms may be seen as vertical silos whilst nursing takes a more holistic stand. Indeed, Manley (1997) concurs, stating that many new posts develop at the nursing-medical interface making them specialist posts rather than advancing practice roles.

For Manley (1997) then, the purpose of advanced nursing posts should be to move nursing forward and often encompass sub roles such as educator, researcher and consultant. For Sutton and Smith (1995) advanced nursing practice differs to expert and specialist practice because of the way advanced nurses think, see and experience nursing practice, which in turn is purposeful, directed toward excellence and is pragmatic. Moreover, Sutton and Smith contend that advanced practitioners reflect on all aspects of care as it impacts patients and are prepared to 'bend the rules' and constantly stretch the boundaries of nursing. They further link their understandings of advanced practice to the work of Tripp-Reimer (1983) and that advanced practitioners use a culturally specific perspective rather than a perspective which seeks to influence higher level policy making to effect culturally universal changes to nursing practice.

For Bryant-Lukosius and Di Censo (2004) the ability to exhibit domains of practice in areas such as clinical practice, education, research and organisational leadership are better indicators of role than title alone and that failure to define roles and goals can hinder the progress of a new role. Debates about educational level still abound with Bryant-Lukosius and Di Censo (2004) noting graduate level at the least whilst Hamric (1989) contests that masters/doctorate is a primary criterion. Notably higher degrees in nursing have been widely available in the USA for many years. Other barriers to advanced practice roles include an over emphasis on using the role to replace doctors and failure to address environmental issues particularly at meso and micro level which may impact role effectiveness.

Having considered how titles of new roles are used and the debates surrounding meaning of the titles, I continue this chapter by exploring the role of community matron, and the

healthcare setting into which the new role was introduced. This role can be seen in light of a new role and also an advancing practice role.

1.16 Community matrons

The role of community matron was first mentioned in the NHS Improvement Plan (DH 2004a), which recognised a need for effective management of the growing numbers of individuals with long-term conditions (DH 2005a).

At this time, the Labour Government had abolished the internal market of the previous Conservative Governments in favour of Primary Care Groups (PCG) which were established as freestanding and accountable to local health authorities with responsibility for community services, including nursing for their area (Watson, 2001). PCGs held budgets and advised the local health authority in relation to decisions affecting commissioning of services (Watson 2001). The intention was for a natural progression from PCG to Primary Care Trusts (PCT). Watson (2001) describes PCTs as independent PCGs who maintain their independence by managing a devolved budget which allows provision of medical services, hospital and community care and prescribing. PCTs remained accountable to local health authorities. Community nursing staff, such as DNs and the new community matrons were employed by PCTs.

In order to improve patient self-management and improve disease management for individuals with highly complex health needs, a case management model was seen as the way forward (DH 2005a). Case management is defined by the Department of Health as the process of planning, co-ordinating, managing and reviewing the care of an individual (DH 2000a). The delivery of case management would be by highly skilled and experienced practitioners who would be known as a community matron or a case manager (DH 2004a). Case management will be examined in depth within this chapter. A Public Service Agreement (PSA) (HM Treasury 2004) stated that a reduction of 5% of emergency bed days would be achieved by 2008 for people with LTCs and in 2005 the Department of Health (DH 2005e) heralded community matrons as being central in the delivery of the PSA target. Community matrons would utilise case management with patients living with LTCs who were at the highest risk of emergency hospital admissions (DH 2004a)

Elaboration of the role came from two documents: 'The case management competences framework for the care of people with long term conditions' (DH, 2005b); and, 'Caring for people with long term conditions: an education framework for community matrons and case managers' (DH, 2006a). An additional document (DH 2006b) aimed to bring additional clarity and also allowed the role to be clearly linked to the Knowledge and Skills Framework (KSF) (DH 2004c).

A competence framework was established listing nine domains of case management pertinent to the role of community matron. Domain A, noted in table 1, distinguishes the role of community matron from that of case manager, implying that the role of community matron can only be undertaken by a registered nurse; other health care professionals having to take the title case manager. The advanced clinical nursing skills noted in domain A are health assessment, including non-differential diagnosis and clinical decision making as well as non-medical prescribing (Bowler et al. 2009) and as such set the criteria for undertaking the role higher than that of registered nurse. Additionally, Bowler et al. (2009) note the need for community matrons to have skills in coordination and effective communication.

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Table 1 Domains – Case Management Competences Framework (NHS Modernisation Agency & Skills for Health, 2005)

Further clarity is introduced by the introduction of four principles which may be applied to each domain (see table 2).

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Table 2 Principles – Case Management Competences Framework (NHS Modernisation Agency & Skills for Health, 2005)

Despite the establishment of a framework around the domains of practice, different models of working by community matron services arose. This marries with the findings of Bergen (1992). Bergen examined how case management had been introduced following the NHS and Community Care Act (GB Parliament 1991) and found wide variation in interpretation of service model and delivery. As with many suggestions which come from the Department of Health, a broad idea is mooted, but the operation of the idea can be left to individual trusts in the 21st century. Drennan et al. (2011) contend that this allows wide variation in service development and role. Initially, community matrons developed as an autonomous role. Part of the role is to coordinate care for patients with long-term conditions across health, social care and third sector boundaries. In Croydon issues were noted in relation to capacity of caseload, which became full, and in relation to difficulties of not having a formal system in which to coordinate. From this, Croydon developed another model: the virtual ward (VW) developed, commonly led by a community matron who works as part of a team who 'offer' case management. Virtual wards use the systems, staffing, and daily routine of a hospital ward to deliver preventive care to patients in their own homes (Lewis 2010). Drennan et al. (2011) noted a dearth of evidence in relation to the allocation of funds to the community matron role. This may be one reason why so many different models of community matron service developed across England. As early as 2004, viability of the role was questioned (Murphy 2004). The target set by the Government was to have 3000 community matrons in post by 2007 with the date being pushed back to 2008 (DH 2004a). Figures collated by The

NHS Information Centre for Health and Social Care demonstrate a slow increase in numbers, but still at less than half of the anticipated figure in 2012 (see Table 3)

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Table 3: Numbers of Community matrons 2006-2012 (NHS Information Centre for Health and Social Care 2009 and 2013).

Whether the drop in community matron numbers in 2012 signifies a future trend remains to be seen. Drennan et al. (2011) did note the absence of the community matron role from documents between 2005 and 2007 and the role has the briefest of mentions in the new vision for district nursing document (DH, NHS Commissioning Board and QNI 2013). The NHS Information Centre does note that community matron numbers have grown at an average of 26.1% per year since role inception. This is significantly more than the modern matron role which has only grown at 15.3%/year (NHS Information Centre 2013).

Initially, the success of Strategic Health Authorities and PCTs in meeting their targets for numbers of community matrons in post was monitored centrally (Healthcare Commission 2007) but central monitoring ceased in 2008 (Health Care Quality Commission 2008). As community matrons continue to exist as part of the healthcare workforce, their numbers are recorded annually by the NHS Information Centre.

1.2 Embedding new nursing roles

As noted, in the UK and more especially in England there is a long history of the development of new nursing roles (Goodman et al. 2010). Bridges and Meyer (2007) note that since 2000 and the NHS Plan (DH 2000a) new roles have been advocated as a means of re-designing and modernising the workforce. On page 27 of the NHS Plan it is noted that patients were often seeing a procession of health care professionals, repeating the same information and being delayed in getting to the right person to treat them. This theme, with

both new and re-engineered roles, continued with further policy in 'Liberating the Talents' (DH 2005c) and Modernising Nursing Careers (DH 2009a).

The introduction of new nursing roles at an advanced level was aimed at keeping skilled nurses at a clinical level, because the previous career structure had meant that career advancement commonly took talented individuals into either education or management (Davies 1995). With the introduction of a non-medical consultant role (thus encompassing both nurses and allied health professionals) (DH 1998), Buchann (1999) describes a desire to harness talented nurses (and AHPs) to be clinically and patient focused. As one of the first new roles at an advanced level, the role of consultant nurse has been examined in several studies in relation to role embedding (Burton et al. 2008; Manley et al. 2008; Drennan and Goodman 2011). Although describing a different role, there are many synergies to the introduction of the community matron role in 2004.

In 2001, Read et al. stated that the result of new roles was often an *ad hoc* set up which reflected minimal consensus of remit and a range of responsibilities and titles. In examining literature relating to embedding of new roles which encompassed nursing and support roles Fletcher et al. (2008) found similar issues. Perhaps unsurprisingly the process of embedding was noted as difficult (Roberts 1994, Ormrod et al. 2004, Bryant-Lukosius and DiCenso 2004). Bower et al. (2004) suggested the following as problem areas: role conflict, disagreement and ambiguity, relationships with other workers, broad range of skills, governance. Seven years later, Drennan and Goodman (2011) report role boundary concerns by clinical nurse specialists from the consultant nurse post and that a lack of clarity and agreement on the sphere of work and responsibilities led to conflicts.

Bridges and Meyer (2007) describe factors influencing success as: well thought out proposals, local enthusiasm, building on existing work, and clear links to organisational and national priorities. In considering specific roles and the success of embedding, Burton et al. (2008) suggest that mentorship, clinical supervision, appraisal, and preparation within an organisation are all important. Gerada and Cullen (2004) consider that clinical governance in primary care should focus on working across interfaces. This would link with the current policy theme which seeks to challenge traditional professional boundaries which have been considered one factor in the slowing down of care to patients (DH 2000b:27).

As embedding is cited as problematic, this may be due in part to lack of support once an innovation had been implemented (Bridges et al. 2007). A lack of continuity can be a factor often associated with high turnover of managers. As Portny (2007) states, any vision which is transformed into a project does not guarantee success. Going further, Bridges et al. (2007) acknowledge that effective embedding requires thought about ongoing issues and as much energy invested after the initiation and adoption stages. The following section explores some factors which may impact embedding.

Drennan and Goodman (2011) indicate the unusual nature of stipulating core functions of a role at national level when introducing the role of consultant nurse. Burton et al. (2008) dispute this by stating that the NHS Plan (DH 2000a) gave minimal detail about role. These divergent views may be considered on a broader policy level. The NHS Plan set down the core functions as: expert practice, with 50% of time spent clinically; a professional leadership and consultancy function; an education, training and development function; lastly a practice and service development, research and evaluation function. How these functions were then articulated at micro level could be considered down to the individual post holder. Part of this process could be considered a direct result of previous experience of the post holder (Burton et al. 2008) and indeed, Drennan and Goodman (2011) found that there was evidence for support of individual post holders rather than the role itself. This lack of role clarity led to poor preparation and little future planning for succession (Charters et al. 2005) and as such could be another reason why roles did not embed.

Whereas the medical profession is clearly defined by specialities, some new nursing roles, such as consultant nurse and community matron have sat more broadly. Guest et al. (2004) mooted that, for consultant nurses, this broke the medical model. It has been noted elsewhere that other nursing groups are concerned about overlap in role and this is seen as a threat (Drennan and Goodman 2011). Indeed, the Queen's Nursing Institute (2006) found conflicting views amongst district nurses in relation to the community matron role with some seeing the then new role as pivotal in case managing individuals with long-term conditions, whilst others felt that if district nurses were allowed to do what district nurses were trained to do, the need for matrons would be eliminated. Certainly there is evidence, which is presented next, which explores limited acceptance of the community matron role and that the role has been much contested (Drennan et al. 2011). Shortly before the

introduction of the community matron role, the role of modern matron was introduced and that is a role which has flourished (Drennan and Goodman 2011). A key distinguishing feature between the two roles is that modern matrons sit within the hospital setting and within medical specialities thus fitting neatly into the medical model.

Such anomalies in how new roles are received and accepted would seem to evidence that nursing is hard to quantify. No matter how many studies report the qualitative aspects of the role, and other aspects of nursing and its power to foster a sense of well-being and partnership with patients, many show that nursing is often 'not seen'.

1.3 Chapter Summary

This chapter has introduced the study and set it within the background and context of an ageing population and increasing numbers of people with LTCs. As such, the role of community matron has been introduced and the use of case management to effectively manage people with LTCs. Chapter 2 examines literature relating to case management and secondly to issues of invisibility in nursing as a means of exploring the community matron role further and issues related to embedding of the role.

Chapter 2: Literature review

2.1 Introduction

In their roles it was envisaged that community matrons would utilise case management in their work with individuals living with complex co-morbid long-term conditions. A general view of historical literature from 1991 has been considered and a literature search was undertaken utilising both community matron and case management as search terms. A second literature search was conducted on invisibility in nursing, using the terms invisibility and nursing.

Section 2.2 offers a review of the literature on case management and community matrons. It is presented in 3 parts: pre community matron introduction (1991-1996 and 1996-2004) and post (2004 onwards). A comprehensive review of the literature pre community matron introduction by Hutt et al. (2004) has been utilised. Their methodology and general outcome measures have formed the basis of a literature review of case management post introduction of community matrons. The themes from the narrative synthesis comprise the areas of: hospital admission, use of emergency facilities, length of stay, functional ability and costs associated with healthcare. Additional themes which emphasise aspects of the community matron role are also presented. These are: role interpretation and set up, case finding and capacity, education and impact of the role.

2.2 Case management

Prior to utilisation of case management as a term in the NHS, it has been used initially in the USA and since 2000 in the UK to offer a broader remit than case management associated with community matrons (Harrison Training 2012). The Case Management Society offers standards of practice and a code of ethics and defines case management as:

‘a collaborative process which assesses, plans, implements, co-ordinates, monitors and evaluates options and services required to meet an individual’s health, social care, education and employment needs using communication and available resources to promote quality cost and effective outcomes’ (Case Management Society UK [CMSUK] (2011)

The following table (3) offers an overview of members, showing specific jobs; employers; client groups; professional backgrounds of those working as case managers (Harrison Training 2012).

Specific jobs in case management service	Employers	Client groups	Professional backgrounds
-Community matron -Care co-ordinator -Case manager -Lawyer -Insurer	-Case management company -Sole trader -NHS -Local authority -Legal firm -Insurance company	-Mental health -Catastrophic injuries : brain, spinal cord, other -Generic case management -Vocational rehabilitation -Paediatrics -Chronic illness/ medical	-Occupational Therapist -Nurse -Physio -Social Worker -Lawyer -Teacher -Speech and Language Therapist -Insurer

Table 4: Professions and sectors involved in case management

The CMSUK definition is broader than that offered by the Department of Health as the process of planning, coordinating, managing and reviewing the care of an individual (DH 2000a). Originally, the principal user group for case management were patients receiving psychiatric services. It was first introduced in the USA in the 1950s before transferring to the UK under the term care management (Lee et al. 1998) under the NHS and Community Care Act of 1991 (Great Britain Parliament 1991).

Although, my work has utilised the King's Fund Report (2004), it also takes a historical look at literature from 1991. The advent of the NHS and Community Care Act (Great Britain Parliament 1991) was instrumental in utilising ideas from the USA around case management. In the UK, the term case management was often interchangeably used with care management at this time.

Bergen (1992) has constructed a useful overview of case management in the early 90s as a continuum and I have chosen to utilise this for my readers:

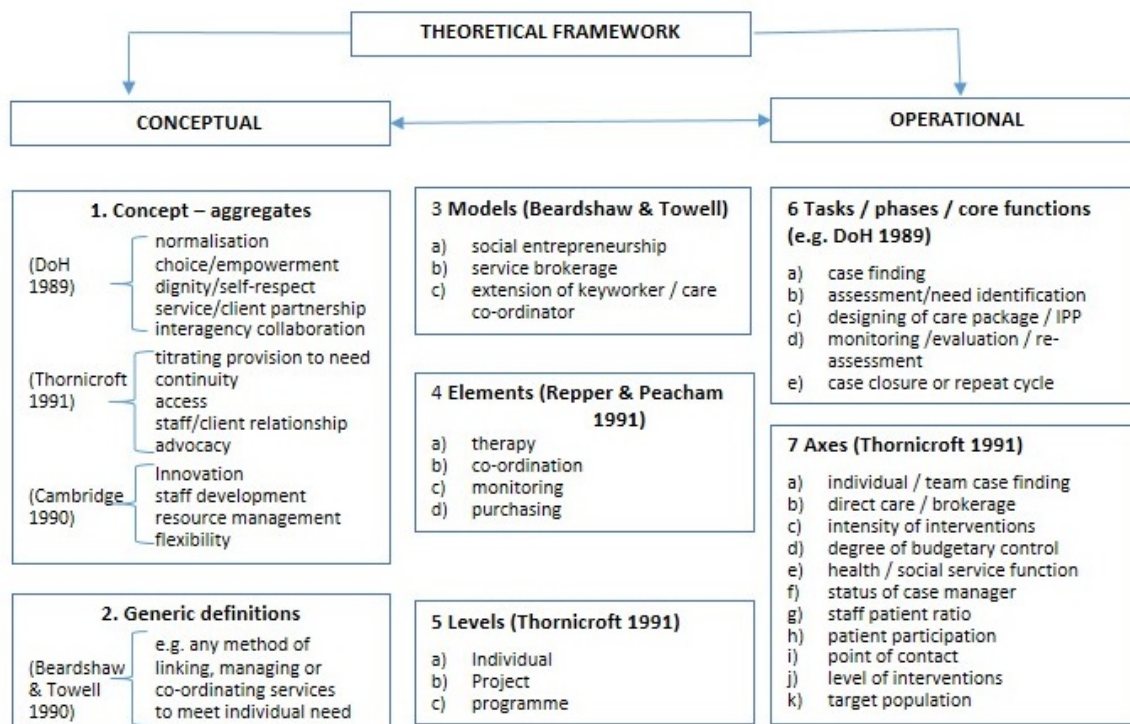


Figure 5: After Bergen (1992) Overview of case management as a continuum

Bergen (1992) offers 4 reasons for the adoption of case management in the UK in the early 1990s. Firstly, well-coordinated community services were required to meet the projections for increasing numbers of dependent people in the community, not least because of the policy of de-institutionalisation. Secondly, to overcome factors which affect care: a paternalistic approach, duplication and fragmentation of services and an inflexible approach. Thirdly, from the boost in care in the community projects and their relative successes. Finally, as the result of Government policy, naming case management as a cornerstone of effective care.

Three models were described by Beardshaw and Towell (1990): social entrepreneurship, service brokerage and extension of the key worker role. Arguably, it is the latter which best describes where community matrons fit some 15 years later. Challis and Davies (1985) found that being case managed allowed frail elderly to remain at home longer than those who were not case managed, in a matched controlled trial.

Having examined 21st century domains of case management in table 1, the elements of case management in the early 90s can be seen to be substantially different (Thornicroft 1991):

1. Individual/team management
2. Direct care/ brokerage
3. Intervention intensity
4. Budgetary control
5. Health and/or social service function
6. Case manager status
7. Case manager specialisation
8. Patient/staff ratio
9. Participation by patients
10. Contact point
11. Intervention level
12. Population targeted

Particularly different, is that community matrons have no budgetary control as part of their remit. Also the ratio of 25- 30 clients per caseload would arguably have brought up capacity as an issue. Individuals, with generic skills, placed within teams has some similarity to community matron models, whilst care delivered in the patient's own home, at an individual level and often with frail elderly resonates with the community matron model (Thornicroft 1991).

Much care/case management was led by social workers (Challis et al. 1991), but inclusion of senior nurses was seen as vital to ensure best outcomes for the frail elderly (Challis et al. 1990). Cultural differences between nurses and social workers and potential tensions is noted by Rowbottom (1992) as a possible pitfall for case management and indeed, Caldock (1993) notes that nurses' definitions of care/case management varied widely from policy directives. With social workers being more used to this system, tensions could be worsened. Bergen's 1994 paper explored the role for nursing in case management concluding that there was activity in the area of case management compounded by huge variation in service practices. Looking at operationalisation was noted as important by Bergen (1992). The domains of case management presented in Table 1 offered this opportunity in what could be seen as a re-ignition of the case management ethos through the role of community matron.

The previous paragraph has explored the broader remit also associated with case management and taken a historical overview from 1991. For the purpose of this work, case management literature has been examined in two parts: 1996-2004 and thus prior to the introduction of the community matron role and post 2004, after the introduction of community matrons.

2.21 Case management prior to community matron introduction

1996 – 2004 (Kings Fund Report 2004)

Much of this literature is grey literature, which commonly represents unpublished work or work which has reported on preliminary findings in order to speed up the process of dissemination (Hopewell et al. 2007). In 2004, Hutt, Rosen and McCauley produced a review of case management for the Kings Fund and their review forms the basis of this section. In the Kings Fund report, the effectiveness of case management for older adults was considered in relation to five major themes which emerged within papers published between 1996 and 2004 and predominantly undertaken in the USA and Western Europe.

The themes are:

- Admission to hospital
- Emergency department visit
- Length of stay or hospital bed days
- Functional status
- Costs

Additionally, minor themes were admission to nursing homes and mortality. Of note is that the main criteria are quantitative in nature.

A total of 19 papers met inclusion criteria out of 118 research papers in total. Major exclusions were mental health which had been the subject of a previous review (Marshall et al. 1998) and any purely hospital based case management papers which had no primary care or community involvement were also discounted. However, it should be noted that two of the 19 papers fell outside the named time frame (Hendriksen et al. 1984 and Fitzgerald et al. 1994) and no rationale is provided for this anomaly. Methodologically, the studies fell into three groups: randomised control trials, controlled studies and before and after studies. The studies, as documented in the report by Hutt et al. (2004) are reproduced in appendix 1.

2.22 Review of evidence on case management 1996-2004 (Hutt et al. 2004)

The studies reviewed in the Kings Fund report used different models of case management although most incorporated both medical and social care. Different methods of selecting patients were undertaken in the studies and this is tabled below (table 5):

Studies	Patient Selection Criterion used
Lynch et al. (2000)	Predictive modelling
Landi et al. (1999) Kemper (1998)	Impairment of function
Boyd et al. (1996) Fitzgerald et al. (1994) Laramée et al. (2003) Pugh et al. (2001) Reigal et al. (2002)	Resource usage (recent)
Bernabei et al. (1998) Hendriksen et al. (1984) Stuck et al. (1995) Allen (1999) Kane et al. (2003)	Population programming
Blue et al. (2001) Boult et al. (2000) Gagnon et al. (1999) Long (2002) Marshall et al. 1999) Schoore et al. (1999)	Combination Modelling

Table 5: patient selection criteria

All the studies, with one exception, considered case management which incorporated home visits. The exception was the study by Riegal et al. (2002) which considered case management by telephone contact alone. The roles of case managers were explored and fell into the following categories:

- Care coordination 17 out of 19 studies
- Clinical or needs assessment 15 out of 19 studies
- Patient education or self-management 10 out of 19 studies

The giving of direct care by case managers was minimal and described in just three studies (Allen 1999, Kane et al. 2003 and Landi et al. 1999).

A variety of case management delivery methods was also noted. On a continuum, this varied from a single contact, which could be questioned as to how this meets the criteria of case management, to interventions which involved 24 hour contact. Additionally, the background of case managers varied. The majority of studies found Masters educated nurses in the role. Boulton et al. (2000) reported social workers as case managers whilst a further five studies reported a combination of nurses and social workers (Bernabei et al. 1998, Kemper 1998, Long 2002, Marshall et al. 1999 and Schore et al. 1999).

The findings of these studies are reported in relation to the five main themes noted by Hutt et al. (2004): hospital admissions, emergency department visits, length of stay/hospital bed days, functional status and costs.

2.221 Hospital admissions

Eighteen of the nineteen studies used hospital admission as a criterion for exploring effectiveness of case management. Studies by Bernabei et al. (1998) and Hendriksen et al. (1984) reported significant differences between the control and intervention groups as a result of case management in their respective RCTs. It should be noted here that despite the search dates stated by Hutt et al. (2004) the work by Hendriksen et al. pre dates this search parameter by 12 years, for which no explanation is given. Similar results were described by Kane et al. (2003) in a controlled study which reported a 50% reduction in hospital admissions as the result of case management. Despite results from all the other studies reporting minimal or no impact on hospital admission as the result of case management, Kane's study proved influential in the UK health policy with the introduction of case management by community matrons for vulnerable patients with co-morbid long-term conditions. In Kane et al.'s (2003) controlled study (the Evercare model) significant reductions in visits to emergency departments were noted. Hutt et al. (2004) note that RCTs using this outcome measure generally failed to replicate such findings.

2.222 Emergency department visits

Of the nineteen examined studies, eight included visits to emergency departments as an outcome measure when examining the effectiveness of case management (Bernabei et al. 1998; Boulton et al. 2000; Fitzgerald et al. 1994; Gagnon et al. 1999; Marshall et al. 1999; Pugh et al. 2001; Reigel et al. 2002; Schore et al. 1999). One study (Bernabei et al. 1998) found a statistically significant reduction in emergency department visits, whilst the study

conducted by Gagnon et al. (1999) found a significant increase in this outcome. The remaining six studies reported no statistical differences between control and intervention groups.

2.223 Length of stay or hospital days

Almost two thirds of the studies used length of stay/ hospital days as an outcome measure. Of these studies, ten were RCTs (Bernabei et al. 1998; Blue et al. 2001; Boulton et al. 2000; Fitzgerald et al. 1994; Gagnon et al. 1999; Hendriksen et al. 1984; Laramée et al. 2003; Long 2002; Reigel et al. 2002; Stuck et al. 1995). The RCT undertaken by Bernabei et al. (1998) reported a 35% reduction in hospital bed days in the intervention group over a 12 month period. Strong results in this outcome measure were also reported by Hendriksen et al. (1984) which reported a reduction of 24% in bed day usage over a three year period.

Of the non randomised studies, two reported a reduction in this outcome. These were studies by Kane et al. (2003) and Landi et al. (1999).

2.224 Functional status

Functional status was used as an outcome measure in six RCTs, with half reporting improvements in this outcome as a result of case management (Bernabei *et al.* (1998); Marshall *et al.* (1999); Stuck (1995)). It should be noted that no exact definition of what functional status comprised was given. One before and after study reported improvement in this area (Lynch et al. 2000).

2.225 Costs

In examining nineteen studies, Hutt et al. (2004) reported difficulties in establishing 'like for like' when considering cost due to the wide variation in methodology across the studies. The findings of RCTs were split between those finding savings and those reporting increased costs as a result of case management. Neither savings nor additional costs were shown to be statistically significant. Findings associated with costs are shown in table 6:

Findings Associated with Cost in RCTs	
Increased cost as a result of case management	Marshall et al. (1999) Pugh et al. (2001) Schore et al. (1999) Stuck et al. (1995)
Reduced cost as a result of case management	Bernabei et al. (1998) Boult et al. (2000) Hendrikssen et al. (1984) Laramée et al. (2003) Riegal et al. (2002) Long et al. (2000)

Table 6: Findings Associated with Costs in RCTs

In attempting to draw conclusions from contradictory evidence, Hutt et al. (2004) urged caution, particularly in transferability of results to the UK, which provides a different health system to that in the USA and in much of Western Europe where the studies were undertaken.

As community matrons utilise case management, in this chapter I present the literature related to case management. This explores literature before the community matron role and afterwards. Since the introduction of the community matron role in 2004, there has been a change in the literature whereby papers which link case management and community matrons have been written, which consider the UK context, more than was apparent before the community matron role came into being.

2.23 Case management in the UK following the implementation of a community matron role

As part of the parent project (see section 5.2), the literature search was conducted to identify research literature on the role of community matrons, case management and case managers as it appeared in UK literature following inception of the community matron role. Therefore, search 1 undertaken in 2010 built on the review undertaken by Hutt et al. (2004). A second literature search was undertaken in November 2012, again using the search terms community matron and case management. The search was conducted primarily using online bibliographic databases. The following databases were interrogated:

Database	Coverage: search 1	Coverage : search 2
Academic Search Premier *	Multi-disciplinary academic full-text database 1975 – 2010	Multi-disciplinary academic full-text database 2010-2012
CINAHL (Cumulative Index of Nursing & Allied Health Literature)	Allied health database 1982 – 2010	Allied health database 2010-2012
MEDLINE	Major biomedical database 1950 – 2010	Major biomedical database 2010-2012
SCOPUS*	Multi-disciplinary database 1996 – 2010	Multi-disciplinary database 2010-2012

Table 7: Case management Search 1 and 2*Controlled subject headings were not available in these databases so searches were conducted using free text keywords only

Search strategy

A combination of Controlled Subject Headings (SH) and free text or keywords (KW)¹ was used as a search strategy for each database where applicable. The search was undertaken in each database with UK published research limitations being applied where available. The research team then identified relevant studies.

1. Community Matron* (KW)
2. Case managers (SH) OR Case manager* (KW)
3. Case management (SH) OR Case management (KW)
4. (1 OR 2 OR 3) (limited to research articles published in UK titles)
5. Case finding
6. (1 OR 2 OR 3 OR 5) (limited to research articles published in UK titles)

For search 1, CINAHL there were 161 references in total. This reduced to 160 when limited to UK publications and was further reduced to 21 references if limited to research articles. On MEDLINE there were 78 references in total: no limits were applied. After applying

¹ Subject Headings are a controlled vocabulary that is designed to eradicate the problems associated with free text. A subject heading will take account of synonyms, antonyms, plurals and variations in spellings. Subject headings are normally allocated to a bibliographic record after the article has been thoroughly read.

A keyword search will scan the bibliographic record for any occurrences of the word or phrase that has been entered. It will only search for the string of characters entered and may return results that are not relevant but contain the word or phrase.

inclusion and exclusion criteria, 26 research studies were included. One exception to the inclusion/exclusion criteria (Roland 2005) was included because of its relevance to hospital admissions in individuals with co-morbid LTCs.

Inclusion criteria: Studies which included case managers who were nurses/ community matrons. Studies which included views of patients and carers, case managed by a nurse/community matron. Research studies conducted in the UK and in English were included.

Exclusion criteria: Studies which included case managers of whom none were nurses/community matrons. Studies which did not report research, were not undertaken in the UK or those not reported in English.

For search 2, inclusion and exclusion criteria were largely the same as the original literature review undertaken in 2010, but also took into account studies which relied on participants other than community matrons but were commenting on the community matron role or service. Academic Search complete offered 34 results, Medline gave 11 and CINAHL 8. At this point, research articles which looked at the role of community matron and its impact were reviewed. This comprised 10 articles, which are highlighted in pink in table 8. Those articles which mentioned community matrons in passing have been incorporated as background where appropriate in my study.

The studies examined in depth are tabled with key themes highlighted. At this time, studies did not mirror the themes of Hutt et al. (2004), but generally the emphasis of papers was on the community matron rather than case management *per se*.

Hand searching

Community matrons are a new role and as such a controlled subject heading was not available. So a thorough hand search was conducted of the results of the keyword search and any relevant studies identified from further reading of the abstracts. These were then submitted for consideration by the research group. No individual journal titles were identified as being especially relevant.

Grey literature

In order to identify policy documents, unpublished research and other forms of grey literature an advanced Google search was conducted. Keyword and phrase searches were undertaken in the “.nhs.uk” and “.ac.uk” domains to identify ongoing work being conducted by either the NHS or Higher Education. All relevant documents were passed to the research group for consideration.

Follow-up searches

Relevant identified studies prompted follow-up searches using allocated controlled subject headings and relevant references.

Other databases

Negligible results were returned from searches on other social care databases such as ASSIA and the British Humanities Index.

In total, since the introduction of the community matron role in 2004, 26 studies have been considered and comprise 13 reporting qualitative findings, 5 reporting quantitative data and 8 offering a mixed methods design. More qualitative data was found than in the earlier review by Hutt et al. (2004). The paper by Gravelle et al. (2007) was a mixed methods study but only reports quantitative data in the published paper. Additionally a systematic review by Burns et al. (2007) was also used. An overview of the studies can be seen in table 8 which is presented alphabetically by first author surname. Search 1 papers are highlighted in blue and stage 2 papers in pink in table 8.

Where appropriate, outcome measures were linked to those used by Hutt et al. (2004) comprising hospital admissions, emergency calls, length of stay, cost and functional status, but as later studies were increasingly qualitative additional headings were utilised. These are: role interpretation and set up, case finding and capacity, education and role impact.

The outcome measures will be examined by theme. Additional grey literature is included.

First author and country of study	Study design and features			Outcome measures/results								
	Design	Number of participants	Case manager	Hospital admissions	Emergency calls	Length of stay	Cost	Functional status including physical care/Psychosocial/advocacy	Role interpretation/set up	Case finding/capacity	Education	Impact of role
Armour (2007) England	Postal survey	119/218 GPs, CM, practice manager	CM						√		√	
Banning (2009) England	Focus group	5	CM								√	
Brown (2008) England	1:1 interviews	24 patients	Nurse (specifically CM)			√		√				
Challis (2011) England	Questionnaire/ Interview/ Focus group	50/152 Service managers Practitioners (5-11)	None					√				
Chapman (2009) England	Focus Groups	31 health & social care professionals (CM, GPs, DN, SW)	Nurse (specifically CM)		√			√				
Clegg (2008) England	Postal survey	56/106 responses from patients and carers	CM	√					√		√	√
Cubby (2010)	Semi structured interviews	9	CM						√			
Dossa (2010) England	Focus groups	12	CM						√		√	

First author and country of study	Study design and features			Outcome measures/results								
	Design	Number of participants	Case manager	Hospital admissions	Emergency calls	Length of stay	Cost	Functional status including physical and Psychosocial/advocacy	Role interpretation/set up	Case finding/capacity	Education	Impact of role
Drennan (2011) England	Document analysis Semi structured interviews/ In depth case studies/ reflective interviews	111 policy documents 36 local strategies 49 local documents 41 Directors of nursing 30 other participants (commissioning roles, managers, GPs)	None (but commenting on CM initiative)						√			
Elwyn (2008) Wales	Qualitative set in wider evaluation	5 case managers	Nurse	√				√				
Fletcher (2009) England	Before & after	418 patients	Specialist Workers for Older People (nurse, not CM, SW, housing)	√	√	√	√					
Gaffney (2009) England	Before & after	19 patients	Nurse (specifically CM)	√	√	√	√					
Gage (2012) England	Case study	12 case managers 33 patients	Nurse (CM, CNS, senior DNs, care home case manager)	√	√		√					
Girod (2008) England	Documentary analysis Questionnaire Telephone interview	47/70 17	CM								√	
Grange (2011) England	Interviews	6	CM	√						√		

First author and country of study	Study design and features			Outcome measures/results								
	Design	Number of participants	Case manager	Hospital admissions	Emergency calls	Length of stay	Cost	Functional status including physical care/Psychosocial/advocacy	Role interpretation/set up	Case finding/capacity	Education	Impact of role
Gravelle (2007) England	Controlled before & after	62 Evercare practices 6960-7695 control practices	Nurse(specifically CM)	√	√							
Hall (2011) England	Observation case finding	7 CM 2 GPs	CM							√		
Iliffe (2011) England and Wales	Telephone interviews 1:1 interviews	41 community nurse managers (CMN) 12 nurse case managers 12 GPs 5 community service managers	Nurse						√			
Leighton (2008) England	Pts: self completed questionnaire GP's: telephone interview	123 patients/carers 48 GP's	Nurse (specifically CM)	√								
Manthorpe (2012) England	Case studies Face to face and telephone interview	12 nurse case managers 51 patients and carers	Nurse (CM, DNs, CNS, care home case manager)					√				
Roland (2005) England	Analysis of hospital admission statistics	227 206 “high risk” patient data	Not stated	√	√							

First author and country of study	Study design and features			Outcome measures/results								
	Design	Number of Participants	Case Manager	Hospital admissions	Emergency calls	Length of stay	Cost	Functional status including physical care/Psychosocial/advocacy	Role interpretation/set up	Case finding/capacity	Education	Impact of role
Sargent (2007) England	1:1 interviews	72 patients 52 carers	Nurse (specifically case management)					√				
Sargent (2008) England	Indepth interviews	46 case managers 5 clinical leads 6 programme leads								√		
Simm (2011) England	Questionnaire Interviews	9 CM	Nurse (specifically community matron)								√	
Williams (2011) England	Interviews	14 service users	Service users on CM caseload					√				√
Wright (2007) England	Semi-structured questionnaire	100 patients	Nurse (specifically CM)	√		√	√	√				
KEY CM= community matron, DN= district nurse, CNS= clinical nurse specialist, GP= general practitioner, SW= social worker, Literature Review 2005-2010, Literature Review 2010-2012												

Table 8: Overview of reviewed studies: case management

2.231 Hospital admissions

Of the 26 studies considered, 8 explored hospital admission as an outcome measure for case management. As noted by Hutt et al. (2004) the use of different methodologies within the studies made it difficult to assess effectiveness. An influential study by Gravelle et al. (2007) which evaluated the Evercare pilots in the UK found no significant impact on hospital admissions as a result of the initiative. This was a very different finding from that of Kane et al. (2003) whose original work in the USA on Evercare had found a dramatic reduction on hospital admission as the result of case management. In 2007, Burns et al. reported on a systematic review and meta-analysis of RCTs, concluding that high baseline hospital usage or similar high usage in a control group made it more likely that intensive case management would reduce hospital admissions, but this supposition is not borne out in other literature.

Roland et al. (2005) used hospital episode data to explore routine admissions and found that bed usage in high risk groups, such as individuals with long-term conditions fell over a 4-5 year period of exploring admission rates. As this study did not include mortality, this may be a reason for the fall. Leighton (2008) notes that mortality does affect future usage of services. Roland et al. (2005) explain their results as counter-intuitive because there is an expectation that with increasing age and frailty hospital admissions would increase in this group. As such the reason for the fall could be associated with case management. The authors go on to suggest that wider criteria than just hospital admissions should be considered, although give no indication of what these wider criteria might be (Roland et al. 2005). Gage et al. (2012) also found that hospitalisation was not impacted by patients with co-morbidities or increasing age or greater numbers of medications. Conversely, Grange (2011) found that more hospital admissions occurred in this fragile group of patients as size of community matron caseload grew, and is in line with earlier findings by Sargent et al. (2008).

Two before and after studies report differing results about hospital admissions (Gaffney 2009, Fletcher and Mant 2009). In Gaffney's study descriptive statistics are used to show a reduction from eighteen admissions to one when comparing six months prior to the introduction of a community matron and six months afterwards. For Fletcher and Mant

(2009) who examined 418 participants, there was a non-significant reduction in hospital admissions.

Leighton et al. (2008) reported the qualitative elements of a mixed methodology study which evaluated community matrons in a large metropolitan city in England. Patients and carers reported that they and their relatives had fewer hospital admissions. In addition, GPs interviewed by telephone also considered that hospital admissions for their patients had been reduced as a result of the introduction of case management by community matrons. The authors note that the self-selecting nature of participants may represent a bias in opinion and yet for these participants, their view of reduction in hospital admissions was clear.

A further two papers explored the theme of hospital admissions from a qualitative perspective (Wright et al. 2007 and Elwyn et al. 2008) in relation to the introduction of case management by community matrons. Wright et al. (2007) asked patients about their experiences and 50% (n=82) reported that they had not been admitted to hospital since being on a community matron caseload and of those who were admitted, 36.5% (n=30) were *not* admitted as a result of their long-term condition. It was noted that thirteen patients were admitted to hospital three or more times during their time on a community matron caseload, however the advanced skills of community matrons may be a reason as to why admissions increased, which may have been required rather than inappropriate admissions. Elwyn et al. (2008) asked case managers to review admissions to hospital. They report 22% of case managed patients being admitted, but the context for this figure is poor and as such it is difficult to draw conclusions.

Overall, evidence is weak to show the effectiveness of case management in reducing hospital admissions for individuals with long-term conditions and yet qualitatively there is a strong perception that admissions have been reduced.

2.232 Use of emergency facilities

This theme was considered in 5 out of the 26 papers examined, although interpretation of what constituted 'emergency facilities' was broad comprising:

- GP contacts

- Out of hours contacts
- A & E admissions
- Ambulance contacts
- Home visits for GPs

Gaffney (2009) found reductions in all areas as a result of case management by community matrons. By conducting focus groups with GPs, Chapman et al. (2009) reported a reduction in visits to the surgery and requests for GP home visits as a result of minimal community matron input, so GPs in this study felt there had been a positive impact in reducing their workload through the introduction of case management. On the same theme, but showing slightly different results, Fletcher and Mant (2009) reported a reduction in home visit requests to GPs but an increase in surgery appointments, which the authors put down to an increase in the ability to self-manage and proactivity by patients. Wright et al. (2007) asked patients who they had contacted on feeling unwell before they had a community matron. 86% reported ringing the GP whilst 12% had resorted to dialling 999. The authors reported a change with the community matron being the first contact of choice. In a later study, Gage et al. (2012) found that patients on a community matron caseload were just as likely to have emergency hospital admissions as those case managed by a non-community matron case manager.

2.233 Length of inpatient stays

Again, five out of the 26 studies used this outcome as a measure of the effectiveness of case management by community matrons. Although Gaffney's (2009) study showed effect, the others did not. Gaffney reported a saving of £45 402 when comparing bed days pre and post introduction of a community matron. In exploring Evercare pilot sites, Gravelle et al. (2007) did not find an impact. This study made strenuous attempts to allow for baseline differences in both the control and intervention groups adding to the robust nature of this work. Burns et al. (2007) made suggestions for a model of case management which followed that of assertive outreach teams in mental health. Through a meta-regression analysis, they considered that this type of model was most effective in reducing length of stay (Burns et al. 2007). Difficulties in obtaining complete data sets was noted by Fletcher and Mant (2009) who had hoped to explore data on length of stay which had proved difficult because so much of the data was incomplete and thus

rendered their ability to make useful comparisons in their before and after study almost impossible and easily skewed by a few individuals who had very long hospital stays.

2.234 Patients' functional ability

Functional ability, as noted by Hutt et al. (2004) in the Kings Fund report was used as an outcome measure. This term, which generally is associated with physical abilities rather than social and psychological aspects of health was more difficult to translate in the current studies reviewed. However, Brown et al. (2008) reported patients had a reduced requirement for social and psychological care and fewer went into residential accommodation as a result of case management, so it may be concluded that functional ability was positively affected. Similarly, Williams et al. (2011) reported patients' views that their care was improved through access navigated by community matrons, through advocacy and that they received support which benefitted them socially and psychologically. A study by Challis et al. (2011) also noted advocacy, care coordination and psychosocial care as key aspects in the work of community matrons which may be considered means of improving functional ability in its widest sense. Elwyn et al. (2008) asked case managers to consider patients who had benefited or not from case management and 53% were considered to have benefitted, although there is a potential for bias in wanting to show effectiveness by case managers and whether this fits the brief of functional ability is dubious.

Sargent et al. (2007) found that case management resulted in early identification of exacerbation, as well as improved concordance with medication and as such a conclusion could be drawn that a smaller reduction in functional ability may follow. Social workers reported that close working links with community matrons via case management allowed social workers to provide appropriate services thus improving functional ability (Chapman et al. 2009). For those patients who had no local authority support, nurse case managers (including community matrons) provided a form of support (Manthorpe et al. 2012).

Sargent et al. (2007) argue that case management goes beyond the definitions provided by the Department of Health. Indeed, Offredy et al. (2009) concur, in that models of case management, understanding over definitions, settings for care delivery and choice of

outcome measures used to evaluate effectiveness of case management leave the picture muddled. This has been shown in the examination of these 26 studies, where evidence of the effect of case management on both hospital admissions and in-patient stay is contradictory and therefore in line with findings from Hutt et al. (2004).

2.235 Health care costs

Savings are hinted at and are therefore more implicit than explicit in many of the studies. As previously mentioned, Gaffney (2009) indicates savings, but before and after studies used to explore cost effectiveness have problems, not least because it is difficult to make allowances for other changes which may be occurring in an organisation or wider society. The use of a randomised controlled trial, or at least a controlled trial such as Gravelle (2007,) are more robust in that they allow for other issues to be taken into account. Similarly in changing first contact, Wright et al. (2007) imply savings. Fletcher and Mant (2009) similarly note cost savings throughout their study concluding that case management is potentially saving costs. Gage et al. (2012) examined costs of case management across nurse groups, including community matrons. Their results found large variations in the cost of case managing patients. Community matrons were the most expensive group, but did provide greater input to their patient group who were older and took a greater number of medicines which perhaps indicates a greater fragility of health. Lupari's (2011) unpublished PhD thesis concluded that targeted case management by nurses was both effective and cost effective. Although a robust study using a prospective non-randomised comparison trial, Lupari states that if patients met criteria for chronic illness case management (CICM), the patient received that care. It was not obvious how capacity was created within the CICM to achieve this.

As mentioned, case management is noted as an effective means of reducing unnecessary hospital admissions in the USA. Having explored the background to the introduction of the community matron role and then literature associated with case management pre and post introduction of the role, I will continue by examining literature associated with other facets of the role.

2.236 Role and role interpretation

There continues to be latitude in interpretation of the community matron role, which has led to confusion (Armour 2007, Cubby and Bowler 2010). Those who support the

case management framework (NHS Modernisation Agency 2005), such as Woodend (2006) suggest that the structure is useful and Clegg and Bee (2008) note that degrees of freedom allow demographic nuances to be taken into account thus ensuring that the community matron role is fit for the community in which the role is performed (Harrison and Lydon 2008, Lyndon 2007). Recent investigation by Drennan et al. (2011) concurs that local nuances are a factor in role interpretation. Feeling that the role of community matron had been imposed on primary care was noted by Iliffe et al. (2011) and could affect role interpretation.

In undertaking a random sweep of ten strategic health authorities for job descriptions associated with the role, differences in requirements were found (Randall et al. 2011a). The domains of 'managing cognitive impairment and mental well-being' and 'end of life care' were those least mentioned. In the parent study to this thesis community matrons were quick to state that they were not mental health trained and also spoke of the myriad of services available at end of life (Randall et al. 2011a). An understanding of case management was important in job descriptions as was non- medical prescribing, although a willingness to work towards these skills was a consideration. Similarly, many job descriptions specifically mentioned case management of elderly frail patients, but Harrison and Lydon's (2008) work noted that high intensity users of service are not necessarily elderly, but rather incorporate individuals across the age spectrum and urged that other marginalised groups with long-term conditions should not be excluded, such as minority ethnic groups.

Since the first in depth description of the role (DH 2005c) there has been discussion in the literature about how the role has been interpreted and implemented and additionally how prepared individuals were when coming into post, including qualifications and experience. The majority of the work is descriptive in nature. Considerable attention focused on the lack of awareness from other health care professionals of the role (Gaffney 2009, Clegg et al. 2006, Dorney-Smith 2007, Harrison and Lydon 2008, Dossa 2011, Grange 2011).

The risks, challenges and benefits of the role have been explored through personal account and qualitative evidence allowing a broader understanding of the role (Armour

2007, Harrison and Lydon 2008). Although initially most community matrons were drawn from a community background (Boaden et al. 2005) there is growing evidence in later papers of community matrons being employed from secondary care backgrounds (Cubby and Bowler 2010). Again, there is debate about what background is best suited with Harrison and Lydon (2008) arguing that community nurses are best placed to take on the community matron role and in so doing improving their career progression.

2.237 Case finding and capacity

Three studies concluded that factors associated with case finding and caseload capacity had an impact on the role of community matron. Sargent et al. (2008) reported that finding and maintaining caseload targets proved difficult and that heavy caseloads made care increasingly reactive, offered poorer quality care and that hospital admissions increased. Grange (2011) suggest that integration may be a means of managing capacity issues, but that further research on caseload size is required. Variability in case finding methods and a tool (PARR) which offers limited success in identifying suitable patients for case management by a community matron are seen as barriers to community matrons (Hall et al. 2011)

2.238 Education for role

In considering how prepared individuals were to take on the role of community matron, the literature points to variance in interpretation of the role, not least the personality and style of the individual in post (Sutherland and Hayter 2009). Additionally preparation is frequently considered in terms of advanced skills and what constitutes an advanced practitioner. Boaden et al. (2005) consider the role in the UK to be more specialised and 'task driven' as opposed to the US model which is more generalist in nature. As such, being 're-engineered' (Boaden et al. 2005) to fit the role has led to practical and educational challenges for those in community matron roles (Lillyman et al. 2009, Banning, 2009, Girot and Rickaby 2008, Brookes 2008, Gaffney 2009). In considering how prepared community matrons were, lack of preparation has been cited as due to the medical nature of the role. A body of writers are strongly critical of this stance noting that the role of community matron requires many key nursing skills such as high level communication skills, a patient centred approach as well as advanced practice skills (Girot and Rickaby 2008, Banning 2009, Lyndon 2007, Armour 2007, Leighton et al. 2008,

Woodend 2006). Overall, training and development needs were seen as paramount to success in the role by community matrons (Dossa 2011).

Implementing case management for individuals with long-term conditions whose health is precarious and fragile requires community matrons to have access to support networks and education in order to fully develop the role; unfortunately strategic health authorities and universities were reported as being ill-prepared to assist in this (Giot and Rickaby 2008, Clegg and Bee 2008, Lillyman et al. 2009). Conflict continues to exist about how to achieve the advanced practice role (Sargent et al. 2007) and whether or not nurses will be willing (or able) to be educated to Masters level (Giot and Rickaby 2008, Lillyman et al. 2009). As well as settling into a new role, acquiring new skills such as in health assessment and non-medical prescribing requires mentorship to oversee competence. An assumption that GPs would act in this role has proved difficult in some areas as well as the fact that this is a role in advancing nursing practice and as such senior nurses were seen as key to the success of mentorship (Giot and Rickaby 2008, Cubby and Bowler 2010). What is not disputed is that a relevant, cohesive educational framework is required to support clinical skill development and role development, but how to achieve this is more contentious (Banning 2009, Woodend 2006, Alsop 2010). Simm et al. (2011) have suggested that employing a solution focussed model, which is an approach that is psychologically sophisticated for enhancing care and wellbeing, can help to empower patients and promote self-care. The community matrons who undertook training in this approach reported favourably in terms of patient outcomes and an increased job satisfaction.

2.239 Impact of the community matron role

Although there is more than one interpretation of the role of community matron, the literature highlights positive aspects of a role which is dynamic and can change according to the needs of service, patients and fellow professionals (Armour 2007, Sargent et al. 2007, Banning 2009). A large amount of evidence exists which shows the popularity of the role of community matron amongst patients and their carers (Leighton et al. 2008, Banning 2009, Lyndon 2007, Clegg and Bee 2008, Armour 2007, Sargent et al. 2007, Schein et al. 2005, Schaeffer and Davis 2004, Gravelle et al. 2007). Patients and

carers who responded to a survey highlighted hospital avoidance, improved links to other services, reliability and increased confidence as specific areas where the community matron role had impacted on them (Clegg and Bee 2008). Additionally, positive collaborations are reported with other health and social care professionals, including GPs, who report confidence and satisfaction with case management by community matrons (Leighton et al. 2008, Armour 2007, Chapman et al. 2009).

Ability to show effectiveness of the service can be difficult and Leighton et al. (2008) report the importance of effective case finding as key in allowing community matrons to manage this complex group of patients proactively. As noted in section 2.237, this is not easy (Sargent 2008, Grange 2011 and Hall et al. 2011). Girot and Rickaby (2008) note that the Kaiser triangle has been a useful way of defining the needs of patients and those who would most benefit from case management. The difficulties noted previously in showing reduction in hospital admissions has been explored by Cotton (2009) who suggests the need to categorise patients as high probability of admission, medium or low, qualified by a known time frame in a bid to establish effectiveness of case management by community matrons.

Themes which emerge from the literature on community matrons comprise improving the quality of life of patients and carers, support to learn self-management skills for patients, working to prevent unplanned admissions and, where unavoidable admissions occur, then working with secondary care staff to facilitate speedy discharge (Clegg and Bee 2008, Armour 2007, Masterson 2007). The latter has been enhanced in some areas through the use of key fobs alerting A&E staff and ward staff to the fact that a patient has a community matron (Downes and Pemberton 2009). Additionally the theme of psychosocial support provided by community matrons to patients and carers is noted as crucial (Schaeffer and Davis, 2004, Leighton et al. 2008 and Banning 2009, Williams et al. 2011). One study, Sargent et al. (2007) found that patients and carers considered psychosocial care to be equally as important to them as clinical care and worked in favour of improving quality of life and overall management of long-term conditions (Clegg et al. 2006, Dorney-Smith 2007).

The studies considered between sections 2.21 and here are divided in conclusions. The quantitative studies have not produced similar results in the UK, as were seen in the USA in relation to case management, particularly in terms of hospital admissions. Conversely, qualitative studies undertaken in the UK continue to show perceived impact on hospital admission rates, as well as many other aspects of the lives of patients and carers with long-term conditions. Similar conclusions were drawn by Lupari et al. (2011) following a systematic review of the case management literature. This perception of reduced admissions also comes from professional sources such as community matrons, and GPs. That community matrons do not come out well when evaluated against such metrics as reducing hospital admission is of concern for the embedding of the role. Williams et al (2011) suggest that patient experience must be taken into account in evaluating the role of community matron. Lilford et al. (2007) argue that measuring process rather than outcomes may be more useful and could be considered a means of adding greater meaning to a role such as that of community matron. In addition, lack of effectiveness using such metrics threatens the ability to market the role to commissioners.

2.3 Invisibility and Nursing

Through the process of interviewing community matrons and analysing the transcripts provided for the parent project, it became evident to me as a researcher that much of the work undertaken by community matrons was not articulated, understood or seen by many. Manley et al. (2008) argued that support was required in order for consultant nurses to make themselves visible. Burton et al. (2008) considered that a strong policy remit, such as new stroke guidelines for the consultant nurses they interviewed, gave consultant nurses an ideal opportunity to make themselves visible. Lack of clarity and agreement in the sphere of work and about responsibilities implies reduced support. Drennan and Goodman (2011) go on to report that despite their ability to work at a high level and to articulate concerns, consultant nurses were unable to delineate discrete areas of work and so to defend their roles. In the category 'many', as mentioned above, I include other nurses, managers, GPs, and on occasions, patients.

As the concept of invisibility seemed to be important, a second literature search and review was undertaken:

Three online bibliographic databases were utilised, namely CINAHL, MEDLINE and SCOPUS.

Search strategy

The search strategy can be viewed in table 9.

Inclusion criteria:

- Papers which explored nursing and nurse roles in light of invisibility
- Papers from available dates within databases
- Papers written in English language (as funds were not available for translation)
- Empirical research
- Non empirical literature (which added to the debate)

Exclusion criteria

- Children aged under 18, because community matrons are responsible for an adult (over 18 case load)
- Papers relating to clinical care associated with medical conditions/ illnesses. The focus of the study was on nursing, not diseases per se and not patient views in relation to the visibility of nursing roles.
- Papers related to nursing image, as this was felt to be a separate area of study
- Papers about popular cultural perceptions of nurses
- Papers about the public image of nursing

Finally, as the thesis explores the role of community matron, the term community was added to further hone the search (see figure 6). A wide strategy was applied initially which was funnelled down as noted by Arksey and O'Malley (2005):

Database	Search terms and limitations	Numbers of records	Database	Search terms and limitations	Numbers of records
CINAHL	Invisib* and nurs*	467	CINAHL	Invisib* and nurs* and community*	45
MEDLINE	English language	510	MEDLINE	English language	38
SCOPUS	Research	384	SCOPUS	Research	360
	All available dates			All available dates	
	All fields			All fields	
	Human			Human	

Table 9: Invisibility Search 1 and 2

A PRISMA chart (see figure 6) has been developed to show the process (adapted from Moher et al. 2009)

Identification

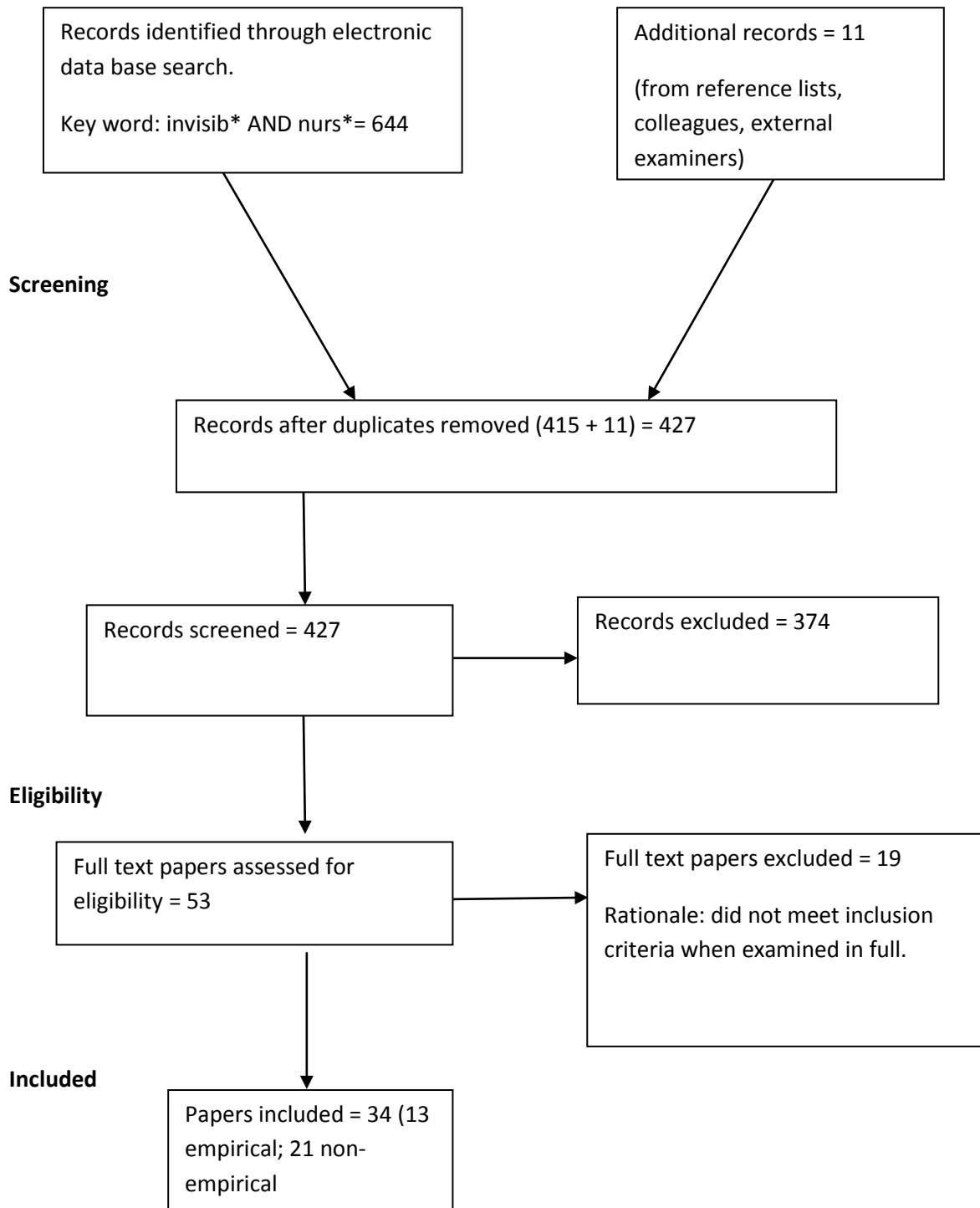


Figure 6: PRISMA chart (adapted from Moher et al. 2009)

One of the most noticeable aspects from undertaking this search was that most authors did not have visibility of nursing as their focus, but rather, it was a concept which emerged through analysis and interpretation in the empirical studies. This was the same in my own work, which initially planned to have policy at its heart. The literature also highlights anxieties in relation to invisibility of nursing work in Australia (Tofolli et al. 2011), and the USA (Roy 2000, Kleinpell 2007, Boyle 2010 as well as the UK (Hallett and Pateman 2000, Harmer 2010, Drew 2011). The context in which nursing work takes place is also varied and linked to invisibility. These areas include intensive care (D'Antonio et al. 2010), rehabilitation (Kearney and Lever 2010), cancer nursing (Boyle 2010), district nursing (Smith et al. 1993, Goodman 2001).

All the empirical studies reviewed utilised a qualitative methodology. The Critical Appraisal Skills Programme (CASP) tool has been used to evaluate the studies (CASP 2013, available at: [http://www.casp-uk.net/find-appraise-act/appraising-the-evidence/\[7/10/13\]](http://www.casp-uk.net/find-appraise-act/appraising-the-evidence/[7/10/13])). In following these guidelines, the most commonly omitted discussion was around whether or not the relationship between researcher and participants had been adequately considered.

In reviewing the empirical literature, the following common themes were noted across the work (summarised in table 10): nurses' views of their own role, invisibility as harmful, invisibility as a force, nursing skills that are invisible, feminist interpretations of invisibility and the use of language. Each of these will be considered. Additionally, other types of literature have been considered. These include literature reviews, reports, theoretical articles, editorials and opinion pieces which all seek to further arguments and debates around the concept of nursing and its visibility.

Author (1 st) Country Article type	Study Design and Features			Themes					
	Research Methodology	Methods	Participants	Nurses' views of own role	Invisibility as harm	Skills invisible	Invisibility as a force	Feminist interpretations	Language
Boyle (2010) USA Empirical	Qualitative	Reviewing websites	40 comprehensive cancer websites			✓			
Canam (2008) Canada Empirical	Qualitative Interpretive descriptive methodology	In depth interviews	16 nurses (clinical nurse specialists)	✓	✓				✓
Drew (2011) England Empirical	Qualitative ethnography	Observation Semi-structured interview	2 teams of district nurses from 1 PCT	✓					✓
Goodman (2001) England and Wales Empirical	Qualitative Case study	Observation Interview	Part 1: DNs GPs Clinical nurse managers (x61 (36 DNs)) Part 2: 2 DN teams (8xDN; 3x HCA)	✓	✓	✓			✓
Hallett (2000) UK	Qualitative	Interview	DN staff nurses x 16	✓		✓			✓
Liaschenko (1995) USA Empirical	Qualitative Lived experience	Interview	Nurses x 19	✓	✓	✓			
Liaschenko (1997) USA Empirical	Qualitative Lived experience	Interview	Nurses x 19		✓	✓		✓	

Author (1 st) Country Article type	Study Design and Features				Themes					
	Research Methodology	Methods	Participants		Nurses' views of own role	Invisibility as harm	Skills invisible	Invisibility as a force	Feminist interpretations	Language
Maben (2006) UK Empirical	Qualitative longitudinal	Interview	Nurses x 26		√	√	√			
McIntosh (2000) Scotland Empirical	Qualitative	Observation Interviews	DNs x 76 from 21 teams		√		√			
Paterson (2009) USA Empirical	Qualitative	Semi-structured interviews Group interviews	Clients x 6 Community members x 7 Staff of other community agencies x 7 Nursing/social work students x 3		√	√				
Rodney (2001) Canada Empirical	Qualitative 2 ethnographic studies	Participant observation Interview	Paper 1 200 hrs of obs on nurses in acute medicine 22 int with 11 nurses	Paper 2 200 hrs of obs Int x 45: Nurses SW,Physicians Clerks Pts		√			√	√
Smith (1993) UK Empirical	Qualitative	Participant observation Group discussion Questionnaire Interview	DNs (from 2 health centres potential 27) Purchasers x 9 from commissioning HAs	√		√				

Author (1 st) Country Article type	Study Design and Features			Themes					
	Research methodology	Methods	Participants	Nurses' views of own role	Invisibility as harm	Skills invisible	Invisibility as a force	Feminist interpretations	Language
Tofolli (2011) Australia Empirical	Qualitative ethnography	Observation In depth interview	Nurses (HDU & CCU) x 15	✓	✓				
Huynh (2008) Canada Literature review	NA	Rodger's evolutionary method of concept analysis	72 papers reviewed		✓				
Illiott (2010) UK Literature Review	NA	Five stage systematic literature review process	33 studies reviewed		✓	✓			
D'Antonio (2010) USA Report	NA	NA	NA			✓	✓	✓	
Maslin-Prothero (2008) UK Report	NA	NA	NA	✓					
Queen's Nursing Institute (2002) Report	NA	NA	NA			✓			✓

Author (1 st) Country Article type	Study Design and Features			Themes					
	Research Methodology	Methods	Participants	Nurses' views of own role	Invisibility as harm	Skills invisible	Invisibility as a force	Feminist interpretations	Language
Bjorklund (2004) Theoretical article	NA	NA	NA		✓			✓	
Colliere (1986) France Theoretical article	NA	NA	NA			✓		✓	✓
De Frino (2009) USA Theoretical article	NA	NA	NA				✓		
Kane (2000) USA Theoretical article	NA	NA	NA		✓			✓	
Kelleher (2003) Australia Theoretical article	NA	NA	NA			✓			
Kleinpell (2007) USA Theoretical article	NA	NA	NA			✓			
Liaschenko (1999) USA Theoretical article	NA	NA	NA						✓
Roy(2000) USA Theoretical article	NA	NA	NA				✓		
Wall (2010) UK Theoretical article	NA	NA	NA		✓				

Author (1 st) Country Article type	Study Design and Features			Themes					
	Research Methodology	Methods	Participants	Nurses' views of own role	Invisibility as harm	Skills invisible	Invisibility as a force	Feminist interpretations	Language
Anderson (1995) USA Editorial	NA	NA	NA			✓	✓		
Kearney (2010) Australia Editorial	NA	NA	NA			✓			✓
Manthey (2008) USA Editorial	NA	NA	NA				✓		
McConnell (1995) USA Editorial	NA	NA	NA			✓			
Biley (2005) UK Opinion	NA	NA	NA			✓			
Conway (1989) USA Opinion	NA	NA	NA			✓			✓
Harmer (2010) UK Opinion	NA	NA	NA				✓	✓	

Table 10: Overview of reviewed papers: invisibility

2.31 Nurses' views of their own role

Smith et al (1993) report nurses feel a need for protection in their roles. As such, a group identity was seen as a valuable means of maintaining this (Drew 2011). Not only are reports of a dominant biomedical model which results in nurses choosing to remain silent (Liaschenko 1995, Canam 2008), there is also a view that nurses can be sabotaged by organisations which seem unable to protect nurses from time pressures, staff shortages and work overload (Maben et al. 2006). For Tofolli et al. (2011), nurses in Australia are caught between budgets in the private sector where hospitals run as businesses and giving quality patient care to enable the business reputation to be maintained. Similarly, in a UK context, Goodman (2001) reports nurses exhibiting skills to integrate and accommodate conflicting demands in order to ensure good care for patients. A very old opinion piece notes some nurses as considering their role as one of being involved as much as possible in the care of patients (Fox 1978). McIntosh's (2000) qualitative study which utilised observation described the skills of nurses falling into 5 categories: practical, interpersonal, observational, cognitive and managerial. A major disadvantage to nurses is their own preoccupations with internal matters, such as day to day requirements of 'getting the job done'. This distracts them (Paterson et al. 2009) and stops them becoming engaged with wider issues such as policy (Maslin-Prothero and Masterson 2008).

As part of general invisibility associated with nursing, a lot of the literature discusses the invisibility in relation to skills and this is examined next.

2.32 Nursing skills that are invisible

Eighteen of the thirty four papers included discussed nursing skills as invisible to a greater or lesser degree. This spanned the timeline over which articles were found, different countries and across different specialties of nursing.

Of overarching importance, Roy (2000) highlights a need for issues and trends to be publicised in order to maintain the visibility of nursing. Anderson (2004) and Kelleher (2003) discuss this in different ways with Anderson (1995) discussing the impact of earlier discharge on a poorly prepared community and primary health service in the USA

and Kelleher (2003) highlighting the continuing dominance of hospitals making community and public health nursing skills difficult to see.

Physical care, which may be expected to be clearly seen, is noted as being invisible (Kearney and Lever 2010). They discuss the difficulties experienced by nurses working in rehabilitation settings, using an example of time spent in the bathroom with patients. Although this time increases patient independence and self-care, the lack of formalisation and documentation means it is invisible. In a similar way, the work of district nurses and community matrons is also not seen because it takes place behind closed doors in a patient's home (Drew 2011). Conway (1989) notes the lack of documentation and formal language used as a hindrance. This is discussed further under the theme of language.

Acting and speaking for others (so patients) is part of the skill set offered by nurses and can embody both physical and psychological aspects of care (Liaschenko 1995). Smith et al. (1993) and Biley (2005) both note the difficulties in showing how psychological care is provided. Fox (1978) considers that psychological care is often not encouraged as it can lead to nurses showing their emotions. Indeed, Liaschenko (1997) stresses the importance of interpersonal bonds and Goodman's (2001) qualitative case study described nurses attempts to meet patient demands which fell outside of clinical care in order to maintain the bond and communication required. Newly qualified nurses struggled to offer holistic care when hurried physical care took precedence (Maben 2006). Making any care visible remains difficult (Colliere 1986).

How to capture skills (D'Antonio 2010) such as the decision making undertaken by nurses (Smith et al. 1993) can be masked by the use of technology (Boyle 2010). McConnell also questions whether preoccupations with high tech care are the reason for other fundamental nursing and caring skills being invisible. Other important skills, such as problem solving and critical thinking skills are also hidden (Smith et al. 1993, Boyle 2010) and getting them seen remains a challenge. Through observation and interview with 76 district nurses, McIntosh (2000) concludes that nursing skills which are difficult to see fall into 3 categories: cognitive, inter personal and managerial.

An interpretive literature review of protocol based care which examined 33 papers concluded that activities and roles of nurses were so poorly articulated as to be almost entirely invisible (Illiott et al. 2010). It is perhaps not surprising then, that another theme which pervades this body of literature is that of invisibility as harmful. This will be examined next.

2.33 Invisibility as harmful

Thirteen of the papers examined considered that the invisibility of nursing is harmful. Bjorklund (2004) considers that values which are inherent in caring and nursing work are not seen and therefore this harms both nurses and nursing as a profession. Some of the difficulties in articulating work make it difficult for nurses to secure funding from administrators (Canam 2008). Tofolli et al. (2011) in their ethnographic work with 15 hospital nurses found that private health care organisations in Australia failed to identify nursing work within their payment systems arguably putting nursing budgets at harm. Rodney and Varcoe (2001) consider how rationing, which is often based on a poor understanding of what nursing comprises, affects patients as well as nurses, causing harm. Unacceptable variations in nursing practice add to the risks of harm (Illiott et al. 2010)

That much of nursing is intangible (Goodman 2001) and that social, political and economic contexts often means that nurses are expected to juggle numerous commitments (Paterson et al. 2009) causes harm. Such balancing work, particularly when it diverges from the interests of medicine and management, can result in emotional harm (Goodman 2001). This mirrors Maben et al's (2006) recognition that the high values nurses have on completing their training are not always mirrored by existing staff, putting them at risk of emotional harm to the extent that some nurses left the profession. Liaschenko (1995) notes moral harm when there is loss of integrity in their practice. Additionally, Huynh et al (2008) contend that emotional labour (which helps nurses to deal with emotions) underpinning caring is also invisible and as such nurses are regularly put at harm because the complexities of their work is poorly understood. For Wall (2010), nurses continue to work in a system which has *an inflated regard* (Wall 2010: 155) for technology and high visibility services. This has created a tension between the art and science of nursing where the invisibility of caring is lost next to a scientific

and highly rationalised and technology driven work place. In 1971, Lewis noted that by clinging to either a medical or nursing need rather than considering the patient as a whole and who could actually provide bonafide care left nursing invisible. She argued that this was harming both patients and nurses.

Fragmentation of other services often means that nurses fill in the gaps (Liaschenko 1997). Goodman (2001) considers that nurses have great capacity to absorb the expectations of others, yet in so doing harm may be caused to them as individuals and the profession. This will be further explored in relation to the work of Liaschenko in section 3.2.

Invisibility in nursing causes harm, but there are debates which consider that invisibility can be a positive force. This is examined next.

2.34 Invisibility as a force

This theme in the literature has a largely American bias (Anderson 1995, D'Antonio 2010, De Frino 2009, Manthey 2008, Roy 2000). In Manthey's (2008) opinion, there is a covenant between nursing and society which is based around caring and it is this covenant which is a power base for nursing. There are calls for nursing to challenge oppression and to use it for good by using the numerous opportunities which are open to nurses (Harmer 2010), whilst Manthey (2008) contends that nurses should *be* responsible for changes to the profession rather than having change forced upon them. Roy (2000) postulates that by combining personal and professional values, which are often invisible, with more visible fields of trends then there will be a greater power base for shaping future directions in nursing. Re-reading history should enable nurses to move away from feminist teachings of powerlessness and instead take heart from the strength, purpose and political action which has also been a part of nursing throughout history (D'Antonio 2010).

De Frino (2009) has built a theory for nursing based on a study of women in engineering (Fletcher et al 2000). In this work, De Frino considers that relational work of nurses exists and is not seen and yet this particular work is actually a source of power and value which, if re-organised could be clearly seen as the means by which nurses achieve

positive patient and professional outcomes. The relational work undertaken by nurses and which De Frino (2009) considers being invisible includes:

- Gaining information of a clinical nature
- Teaching
- Giving information
- Communicating with patients
- Rapport talk

In essence the latter is a means by which knowledge is explored in a wider context, which makes the care of a patient run smoothly and it is this connection to work which is not measured or visible and is often credited to the doctor, as noted by Liaschenko (2002). It could be argued that changing emphasis in favour of communication to effect health behaviour change may make aspects raised by De Frino (2009) increasingly visible and offer a positive outcome from the invisibility.

2.35 Feminist interpretations

For feminists, the apparent invisibility of nursing stems from the fact that the majority of nurses are women (Colliere 1986, Davies 1995). In a theoretical article which explores historical perspectives, Colliere (1986) describes care as being at the roots of women's history stemming from their role as child bearers which established them as nurturers, as well as caring for those who die as a result of childbirth. In contrast men as hunter gatherers met with accidents and injuries resulting from hunting and this in turn raised their awareness of the body as they attempted to heal such wounds.

Care, notably by nuns, became linked with the expansion and growth of Christianity, but in relation to reducing suffering through talking and advice rather than anything to do with the body which was often held as pagan (Coliere 1986). The situation did not improve with the establishment of nurse training under Florence Nightingale; despite her best efforts the gulf between care and cure widened (Colliere 1986). In promoting the role of the nurse, two aspects flourished: moral aspects from those in religious orders and technical aspects from doctors with Colliere stating that:

'Anything related to care became taken for granted, considered unworthy, required 'lower skills' and scanty knowledge linked to routine procedures' (Colliere 1986:102)

This work was written in 1986 but Colliere concludes that care continues to be invisible, despite its worth in hospitals and homes and yet those who care remain relatively unknown. Liaschenko (1997) concurs noting that nurses' concerns often go unnoticed and are not listened to because they work in a gendered space. Liaschenko does not openly acknowledge a feminist agenda in her work (Liaschenko 1995, 1997), but this aspect is evident in Bjorklund's (2004) paper examining her work. Kane (2000) argues that not using an overtly feminist language is harmful to nursing and its ability to be seen. In her article, Kane (2000) maintains that it remains important that nurses understand the links between nursing and feminism, because without this understanding gender issues will continue to influence nursing in male-dominated societies. Harmer (2010) notes there is a consistency in men progressing to higher positions than women within the nursing profession. Whilst acknowledging the feminist agenda, D'Antonio et al. (2010) seek a changed perspective in relation to invisibility as a power source and this was explored under that theme heading (above). A commonality in these papers is that the nursing voice is silent, and as language, used or not, occurs in many articles, it is considered next in relation to invisibility

2.36 The use of language

Conway (1989) notes a lack of universal language which hampers the ability of nursing to be seen. Literature on the subject of invisibility has been examined. The use of language (or lack of it) is a recurrent theme in 10 out of 33 papers considered. Colliere (1986: 109) states that nurses need to stop saying: *'it's nothing'* and be open about what they do. This idea is extended by Lawler (1991) who coins the term *'minifisms'* which refers to nursing work being understated. The seemingly common problem of invisibility across nursing disciplines lends itself to Silverman's (1992) comment that peoples everyday work is more sophisticated than it is easily possible to articulate

Drew (2011) commenting from an ethnographic study which looked at two DN teams in one Primary Care Trust concluded that district nurses need to understand and be able to articulate what they do and how they do it. In another qualitative study that interviewed 16 staff nurses who worked on the district, the authors acknowledge an instinctive

aspect within their work, which is difficult to express (Hallett and Pateman (2000). Goodman (2001) explores the use of metaphor in nursing language and notes the RCN's (1992) analogy of nursing being like mending: that when it is done well, it is invisible. The Queen's Nursing Institute (2002) speaks of nurses as sponges, who absorb problems other disciplines decline.

Part of language is seen as the ability to accurately document what is being done (Kearney and Lever 2010). Therefore, not documenting accurately leaves nursing invisible (Kearney and Lever 2010). Conversely, in a study employing a qualitative interpretive descriptive methodology, and interviews with 16 clinical nurse specialists (although how this sample was found and what ethical strategies were used is not clear), Canam (2008) concludes that nursing should promote its practice knowledge base as a language for making nursing visible and move away from concentrating on what nurses do. Liaschenko and Fisher (1999) adopted a similar theory which sought to highlight and articulate nursing knowledge in relation to case, patient and person knowledge (see section 3.21 and figure 7).

2.4 Chapter Summary

In this chapter, I have examined literature pertaining to case management and invisibility. A historic and current perspective has been offered. Case management is an established framework in nursing, yet generally, the literature does not show this as a successful framework which has allowed embedding of the community matron role. In addition, I consider that there is a gap in the invisibility literature in relation to autonomous roles, such as community matron, in a community setting. This will be further expanded in section 3.3 after the work of Liaschenko and the paper by Liaschenko and Fisher (1999) which has been instrumental in the development of my thesis has been presented. The next chapter examines the rationale for this in depth.

Chapter 3: Theoretical Framework

3.1 Introduction

This chapter explores the work of Joan Liaschenko and the rationale for using her work as a theoretical framework. Other potentially useful theoretical frameworks have been examined too (section 3.22).

3.2 The work of Joan Liaschenko

I was alerted to the work of Liaschenko by a colleague and fellow nurse. In reading the work of Liaschenko I found similar reports of nursing work being invisible in line with data gathered for the parent project, but which Liaschenko had gone on to theorise. As I read, I was aware of the number of times I agreed with what I was reading, which could be described as phenomenological nodding (van Manen 1990).

The body of work developed by Liaschenko now spans almost 20 years but it is her earlier work which, in my opinion, generates the strongest ideas. Often the newer work continues to build on the original ideas.

The overriding concept in Liaschenko's work (1994, 1995, 1997, 1998, 2002; Liaschenko and Fisher 1999; Liaschenko and Peter 2004) is that of ethics and how nursing ethics in particular, sit within a medical world. The ideas which stand out, for me, are those of invisibility and concepts around boundary work. Invisibility is work that is undertaken, but is hard to record and measure and boundary work defined as work at the edges of nursing and healthcare. Liaschenko links these concepts to gender and also to the power held by the medical profession. For Liaschenko, such power is as much down to gender. Although none of the articles I have read by Liaschenko mention feminism it could be assumed that she has feminism as her theoretical lens (Creswell 2009) whereby women, in this case nurses, face challenges as a result of institutions which frame the situations i.e. medicine. Indeed, Bjorklund (2004) uses Margaret Walker's (1998; 2003) observations on feminist ethics as a theoretical framework on which to examine the work of Liaschenko.

3.21 Invisibility of Nursing (Joan Liaschenko)

In order to understand where Liaschenko's ideas have come from, it is necessary to consider the context in which they were written. Originally the ideas emanated from one study undertaken in the USA (Liaschenko 1995) and before discussing the key concepts, a critique of the original study is offered.

Liaschenko's original study (1995) sought to understand the lived experience, in relation to ethical dilemmas, of two groups of nurses working in home care and in psychiatry. In all there were 19 participants; 10 from home care and 9 from psychiatry. Liaschenko notes that they were all mature experienced nurses as well as being a highly educated group of nurses, with a third possessing a master's degree in the mid 1990s, when Masters level degrees were less common. One question was posed to the participants: *tell me a story from your practice that highlights some ethical concerns you have about your practice*. Polit and Beck (2004) define narrative analysis as a type of qualitative approach which concentrates on the story as focus. Creswell (2009) states that the information is often re told by the researcher, whilst Clandinin and Connelly (2000) suggest that in narrative research the views of participants are often combined with the views of the researcher to form a narrative which is a collaboration of both participant and researcher views. Having read Liaschenko's article, the clearest aspect is the storytelling of participants, rather than the re telling by the researcher and the collaboration of researcher and participant mooted by Creswell (2009) and Clandinin and Connelly (2000).

On reading the article (Liaschenko 1995) which also underpins further writing (Liaschenko 1997), there is a clear sense of the participants, but there are occasions when the reader may require fuller information. For example, there is no information about how the participants were found. As this is a qualitative study the sample is automatically assumed to be purposive in nature, but the reader is not clear as to exact strategies employed. Similarly, the reader is not aware of where interviews were conducted. The sensitive nature of some of the topics reported suggests that interviews may well have taken place away from the workplace. However, if such information were

given, it assists the reader to understand what Creswell (2009) describes as a 'holistic account' (p:176). In a sense, this is an idea expanded by Geertz (1975), who describes the importance of *thick description* (p4) which allows sufficient information to be given about the story which sits behind the qualitative data. In writing qualitative studies for publication, when inclusion of quotes is key to illustrating points, the word count may offer an explanation of why such issues are not discussed by Liaschenko. Similarly lacking is any information on externality or team review of the analysis and findings: aspects which Polit and Beck (2004) state add to the rigour of a qualitative study. A further critique of Liaschenko's work is that the reader does not know what her background is as a nurse; the reader does not know whether Liaschenko was an 'insider' at the point she undertook the empirical research i.e. was working as either a psychiatric nurse or a home care nurse, which could impact the relationship with the participants (Conneely 2002). The reader is left unsure about the motivation of Liaschenko's interpretation, but there are elements of transferability because her work goes on to be echoed in that of Rodney (1998) Rodney and Varcoe (2001) and Bjorklund (2004), as well as my own phenomenological nodding as noted above (van Manen 1990). The overall quality of the presented work is strong and as such the reader feels inclined to be mindful of omissions but not to let them detract from the discussions which are generated.

For Liaschenko (1995) the nursing voice is silent partly because nursing work is portrayed as being embedded in complex institutions and networks of power which often mean that nurses act on decisions made by others. The idea is such that nursing is constrained by bio ethics, or the ethics of medicine which Aldous Huxley (1974) describes as scientific totalitarianism. Building on this, Liaschenko (1995) describes healthcare as being a network of interlinked bureaucracies where nurses work at the edge. By working at the periphery, much of the work is not seen (Liaschenko 1995). Certainly, the idea of fragmentation is not new in the UK. Thomas (2008) notes the complexities in UK systems where integration of services is often in a vertical direction which is medically focussed and often disease specific. As such interlinking could also be seen as bureaucratic in breaking into another 'vertical silo'. In continuing this theme, Bundred (2006) suggests that failure to communicate information in a horizontal direction, so across potential bureaucracies between other wards, department and

organisations, results in services being less developed and as such a fragmented experience for patients. This idea of fragmentation is explored by Liaschenko (1997). In a further paper, which builds on extracts from the original study, fragmentation in care for patients is noted by the participants and mentioned on many occasions. Liaschenko (1997) develops a powerful analogy using strong visual imagery of the healthcare system constantly shifting like tectonic plates and nurses struggling to prevent patients from 'falling through the cracks'. Undertaking this work, which Liaschenko notes is rarely seen or acknowledged, harms nurses, because it misappropriates their time which ultimately protects faults in the system. This harm may be considered in relation to work quoted earlier in section 2.21 by Goodman et al. (2010) who noted that some activities associated with the community matron role were there to supplement system weaknesses. Although Liaschenko's work is critical of institutionalised medicine, Liaschenko does acknowledge benefits of medicine around stability and reliability.

Liaschenko (1997) notes that two views of nursing are persistent. Firstly, nurses as nurturers, hand holding and carrying out the orders of medical colleagues which Porter (1991) might see as an unproblematic relationship between doctors and nurses, because it does not challenge the power of medicine. Secondly the view that nurses monitor and manage high tech devices, so an extension of medicine. It is partly this latter aspect which sparked my interest in this area. In speaking with community matrons and with patients, many aspects of care which were deemed important by community matrons and their patients were not seen in the same way by commissioners, who appeared to value skills of differential diagnosis and non-medical prescribing much more than factors which affected patients on more than a physical level alone.

Although these views may not be considered inaccurate, they do not encompass the range of work which comprises nursing and as such Liaschenko is further convinced of the invisibility of nursing. For Liaschenko it is not that nursing is seen and yet despite being seen is unacknowledged, but, rather, that it is not seen at all in many facets of the work undertaken by nurses. Not only is nursing not seen by other health care professionals, but it may also not be seen by fellow nurses (Liaschenko 1997). In an article which drew on Liaschenko's and Rodney's work, Bjorklund (2004) considers the

concepts of invisibility but concludes that nursing work is often invisible, but *is* sometimes seen by fellow nurses.

Building on the theme of invisibility in Liaschenko's work is that nurses are oppressed and are often not in a position to make their own decisions. Autonomy is noted to be a key aspect of being accepted as a profession (Rutty 1998), along with having a code of ethics, significant education, and a unique body of knowledge. In their work, Liaschenko and Rodney both note that many aspects of nursing work are invisible and it may be reasonable to say that this is why nursing has struggled to be seen as a profession. Aspects of the work of nursing are not valued by other professions, particularly non curing aspects which do not sit with in the medical model. Recent policy initiatives such as 'Energising for Energy' (DH 2011a) place factors such as dignity and reduction in falls and pressure sores on the agenda which are not curative. Even the development of advancing practice in nursing, of which community matrons could be seen as a prime example, does not appear to have done anything to forward the idea of profession. The idea of advanced practice has been confused by the term 'advanced level practice' being applied inconsistently to different roles and thus creating confusion about the scope and competence which should accompany such a role (DH 2010b). For Liaschenko and Fisher (1999) and Liaschenko and Peter (2004), the idea of nursing being considered as work rather than as a profession or a practice might be beneficial. Their rationale for such a bold statement is that both profession and practice are built on hierarchies which can be harmful whereas work and more especially an ethics of work do not privilege any particular work. This idea is partially based on the ideas of Hoff (2001) who considered that physicians should be considered as undertaking work rather than a profession, because physicians no longer have the same degree of control over their work as they once did. Although this may translate to consultants in the NHS, it cannot be transferred to GPs who run businesses within the NHS. With proposals to ask GPs to commission services as part of the latest health and social care policy (DH 2010a), the reduction in power is not obvious in this context. Whether, then the same concept of profession to work for both medicine and nursing can translate from America may be questionable.

In an effort to put a practical edge on her earlier work, Liaschenko teamed up with Anastasia Fisher to write an article which brought together observations from their separate research. This 1999 paper has a real sense of purpose which aims to provide nurses with a language which explains their specific knowledge in nursing roles and work. It builds on Liaschenko’s ideas of moral harm (1995) and relationships, spatial vulnerability (working at the edges of health care) and gendered space (1997).

Three terms are introduced. These are *case*, *patient* and *person* and each is linked by *social knowledge*. A useful diagrammatic representation is drawn which distinguishes the knowledge base which underpins each area: see figure 7.

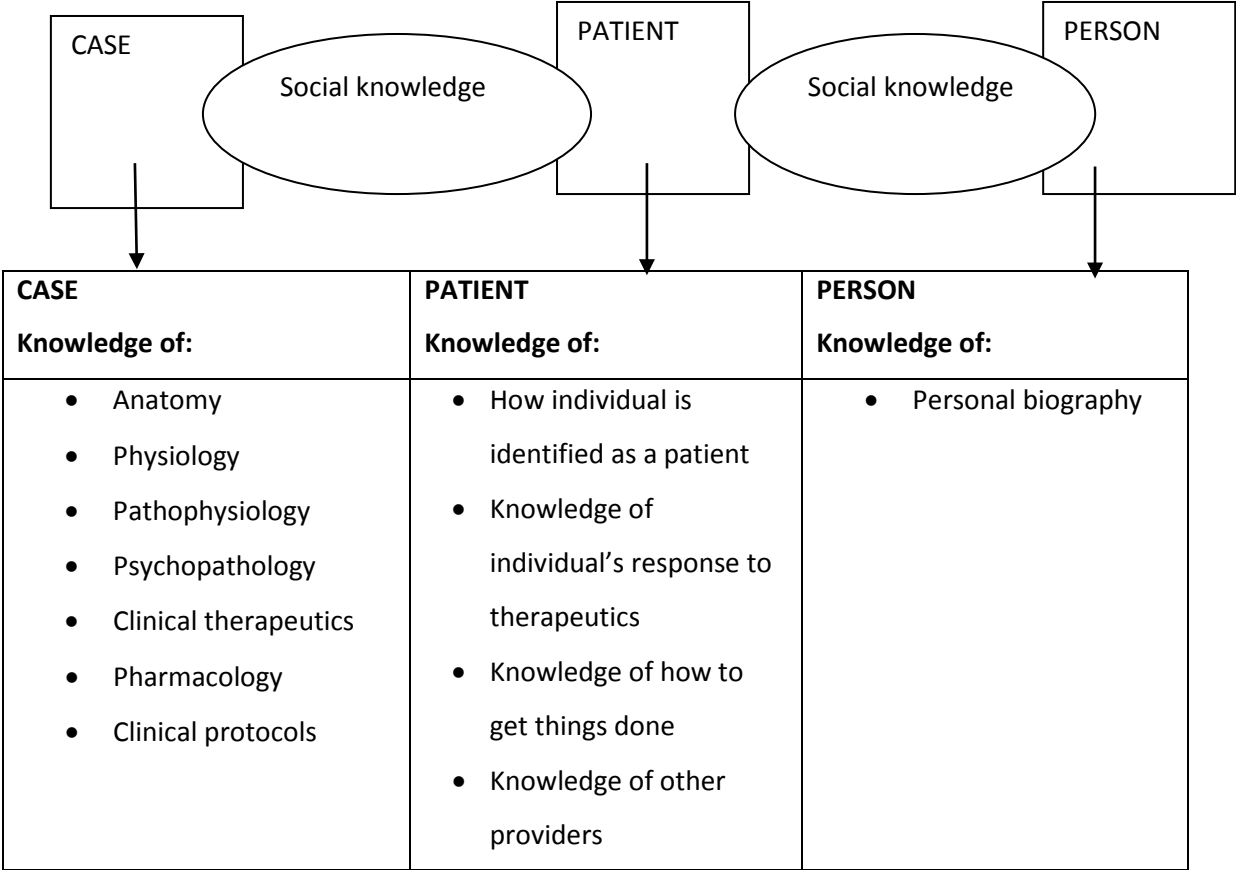


Figure 7: Knowledge that nurses use within the social-temporal-spatial context of their work. Adapted from Liaschenko and Fisher (1999)

Liaschenko and Fisher (1999) consider that nurses are best known for their knowledge of patients and that monitoring recipients of care is the most visible aspect of nursing. In addition to the three areas of knowledge which are highlighted: case, patient and person, Liaschenko and Fisher (1999) consider the importance of social knowledge as a bridge between both case and patient knowledge and patient and person knowledge. At

the first bridge, between case and patient, the authors consider that the knowledge of nurses in relation to other health care professional team members is critical for the organisation of care of patients and ensures that patient needs are matched appropriately to other professionals in the team. The second bridge, between patient and person, allows a social knowledge which goes beyond the boundaries of healthcare. Within this social knowledge nurses are party to social conditions, the impact of disease on individual's ability to function in all areas of their lives, and what stigma may be present in their lives.

As a critique, the model does not explicitly consider the importance of environmental factors which impact on patients' lives. Similarly, the model does not offer a link between case and person, although arguably such links are seen in practice. In summarising, the first bridge between case and patient is seen as a form of localised work which allows general principles to be applied to individuals which allows nursing work to be undertaken, whilst the second bridge between patient and person is distinct because it is general and abstract knowledge (Liaschenko and Fisher 1999). The latter may be considered to be outside the remit of healthcare and yet work in this area is often undertaken by nurses and may be a reason why it is not wholly visible. It could be argued that if nursing was really clear about its model and vision (Graham 2010) then it would be easier to define the remit of healthcare where nursing sits. Liaschenko explores the idea of work further (Liaschenko and Peter 2004). Nursing struggles to be seen as a profession because the nursing knowledge is broad and lacks uniqueness, but in replacing the concept of profession with work, nursing may be able to create independence from scientific practice and thus be able to exhibit the strengths of nursing work (Liaschenko and Peter 2004).

In proposing the theorisation of nursing knowledge, Liaschenko and Fisher (1999) mention other scholars who have examined the subject and most notably Carper (1978) and Benner (1984). However the mentions of both are cursory and the reader is left to decide for themselves how the work of Liaschenko and Fisher (1999) adds to this body of work on nursing knowledge. Liaschenko and Fisher (1999) perhaps assume an existing knowledge in their readership, because their article appears in a scholarly journal, or

that without the knowledge any reader of their work might be prompted to seek out these seminal texts for themselves.

For Carper (1978), the importance of considering the question: 'what it is to know' (p13) is central to her work and she is well known for proposing four types of knowledge which she calls 'fundamental patterns of knowing within nursing' (p13-14). The four patterns identified by Carper are: 'empirics', 'aesthetics', 'personal knowledge' and 'ethics' (p14-20). The first of the four, 'empirics' is effectively the science of nursing and may be seen to link with Liaschenko and Fisher's (1999) case knowledge where scientific aspects such as anatomy and physiology are placed. The second fundamental pattern is that of 'aesthetics' or the art of nursing, which is linked to an understanding and artistry around practical aspects of nursing. In considering the 'fit' of this to the work of Liaschenko and Fisher(1999) it may be that this crosses both patient and person; certainly neither patient nor person are seen in purely scientific terms. Liaschenko and Fisher (1999) note that for them, patient explores a practical side of nursing. The third pattern is that of 'personal knowledge', such that nurses have to understand themselves in order to understand others. For me, Carper's third area of fundamental knowledge is embedded in the bridge of social knowledge between patient and person, which Liaschenko and Fisher (1999) describe as: '*the nurse begins to wonder what living with this disease or disability is like for the individual*' (p37). Finally, Carper's fourth area of fundamental knowledge is 'ethics' or the moral component which requires nurses to understand different philosophical positions regarding ethical frameworks. Surprisingly, this element is less obvious in Liaschenko's and Fisher's (1999) work on knowledge; surprising in the sense that much of Liaschenko's previous work, most notably 1995 and 1997, is strongly driven by ethics and morals. For Edwards (2001), Carper's work is flawed in many aspects, not least because Carper does not define the term knowledge, on which her whole paper is built.

The seminal work, *Novice to Expert* (Benner 1984) identifies five stages in a nurse's development: novice; advanced beginner; competent; proficient, and finally, expert. However, Benner points out that development is not necessarily linear. For Benner (1984), the distinction between practical nursing knowledge and theoretical nursing

knowledge is important. Edwards (2001) argues that the transition from novice to expert can be seen in a nurse's ability to undertake practical activities and as such may lend itself to the idea that undertaking competencies is a means of developing in nursing. Edwards (2001) notes that such development is reliant on the skills and expertise of those reviewing the nurse as competent. Arguably, this is a mechanistic viewpoint of the term expert which takes the biomedical approach and fails to consider that expert nursing knowledge is also based on the knowledge of social and psychological issues amongst patients. Graham (2003) acknowledges that building a theoretical framework around the biomedical model could lead nurses to pay limited attention to anything other than physical aspects thus ignoring the wider facets of human nature. De Frino considers that relational work is invisible knowledge work which has been devalued and has disappeared under the weight of the biomedical model. Liaschenko (1994) describes the work of nursing as being aimed at helping others in conditions of vulnerability of the body (including the mind), as a result of illness or injury. Key to Liaschenko's conclusions is that part of the vulnerability exists beyond the disease or injury to consider the social and political space as well. An absence of relational and emotional work leaves only an 'inhumane' health care system in Liaschenko's view (2002). It may be argued that this is simply another way of dismissing the medical model in favour of the bio-psychosocial model of health (Engel 1977), although Liaschenko's inclusion of a political element in her commentary (although small but considering that individuals occupy a political space) may take it even beyond the bio-psychosocial model. Arguably, the political element may be considered a part of the social aspect.

Additionally, other writers note a continuing dominance of the biomedical model. In considering an increasing relationship between nurses and technology, O'Keefe-McCarthy (2009) notes that an uncritical view of the use of technology can result in less patient centred care, whilst Sandelowski (1998) notes that technical and scientific care contradicts the touch/humanistic approach perspectives which underpin the moral practice of nursing. Henderson (1994) and Heartfield (1996) note that intensive care nurses are more likely to see patients in relation to the biomedical model because the collection of technical data is seen as more important than personal and psychological aspects of care. Flaming (2001) considers the goals of nursing to be more far reaching

than that of care (Benner 1989); comfort (Morse et al. 1977) and more about pragmatics and the importance of considering patient needs, so arguably physical, social and psychological. This links well to Liaschenko's (1997) notion that knowledge of the person in addition to that of the patient and of case knowledge is crucial for nurses.

3.22 Other theoretical perspectives

To justify using Liaschenko's work as my theoretical lens, I have considered a sample of other theoretical frameworks which could have underpinned my thesis and justify why Liaschenko was selected. Other possible frameworks fall into 3 categories. Firstly, the work of Celia Davies (1995), which explores the gendered predicament of nursing. Secondly, theoretical frameworks from the sociology of professions and division of labour (Turner 1987, Larson 1977, Friedson 1970, 1994) and Abbott 1988) and thirdly, frameworks adopted from social science: normalisation theory (May et al. 2009, May and Finch 2010) and diffusion of innovation (Rogers 1962 [first edition now in fifth edition 2003], Greenhalgh et al. 2004)

In section 3.21, I offered a brief discussion around nursing as a profession, built around Liaschenko's work. Concepts of profession are linked to male dominance and as Davies (1995) highlights, what appears to be a neutral bureaucratic and professional system on the surface really favours a male perspective of work, if examined more closely. The male view values and rewards work that follows logic is autonomous and situated in the public space, whilst undervaluing female work as supportive. Davies (1995) goes on to argue that rewards of status and career advancement follow the perspective of the autonomous worker who is dedicated to the profession and the NHS. Her argument contends that male influences lead to harm for nursing in three ways: firstly by denying professional status because nursing lacks autonomy, secondly, by rejecting nursing's feminine aspirations in holism and nurturing, and thirdly, that the bureaucratic nature of nursing organisation support male hegemony (Davies 1995).

It may be possible to suggest that the developments of nurse practitioners, nurse consultants, community matrons and non-medical prescribing have led to increased autonomy for nurses. These factors combined led me to favour Liaschenko's more instrumental approach to how work by nurses across the boundaries of medical, social

and nursing practices is seen. Had I wished to use a feminist lens, then the work of Davies would have been a valuable addition.

Historically, the division of labour between nursing and medicine was based on a gendered division of labour (Abbott and Meerabeau 1998). This concurs with Davies views about nurses being seen as emotional and sentimental (Davies 1995). The debate about professions from within sociology started with the functionalist views espoused first by Durkheim in the 1930s who noted that professions were important for their integrative function in a rapidly changing society. By the 1960s, Parsons was analysing the professional role of medicine as one of social control of ill health which was seen as deviant behaviour. For the functionalists, characteristics of professions comprised a body of theoretical knowledge, self-regulatory practice and authority over patients (Elson 2004).

By the end of the 1960s, ideals about professional ethics and 'doing good' were critiqued in favour of examining exactly what professionals did. In medicine, which is seen as an obvious profession, the work of Friedson (1970) became influential in offering a critique. Friedson's (1970) central tenet was an examination of the significance of medical power in society and the implications for health care. Of particular note by Friedson (1970) is the importance of autonomy which offers self-control over work terms and conditions as a defining characteristic of professional status. So, as Elson (2004) states, the important factor for Friedson was not about medicine's ability to maintain social order, but rather how medicine had gained autonomy and maintained its position.

The idea that strategies and tactics were utilised by professions such as medicine to gain legitimised autonomy by working collectively is a concept introduced by Larson (1977). In making reference to how professions were defined in the nineteenth century, two aspects of being a profession were noted as central by Larson (1977). Firstly, was the importance of education as a means of restricting entry and secondly, the importance of a scientific basis for medicine which enhanced its credibility. As part of this argument, medical training being linked to a university was an important factor in the success of medicine as being seen as a profession. I would argue that there must be more to being a profession than this alone. For Friedson (1970), medical autonomy was a weapon

which subordinated nursing, and being subjected to 'doctor's orders' meant nursing lacked professional status despite significant advances in control over some areas of nursing work in the twentieth century. Abbott (1988) concurs with ideas about systems of professions which allow contests to emerge between professions and subordination of other occupational groups such as nursing. The idea that medicine would defend its autonomy by defending against encroachment (Friedson 1970) has been tested with increasing numbers of autonomous nursing roles which see nurses with physical assessment and prescribing skills which can rival those of doctors (RCN 2012). Such changes, along with increasing numbers of protocols and guidelines reduce clinical freedoms and have also served to weaken the dominance of medicine (Friedson 1994).

For Savage (1995), such extension of nursing roles could see nurses aligning themselves with medicine rather than with patients and carers and health care assistants and allied health professions thus weakening nurses desire to be a profession. Savage contends that nursing should not necessarily strive so hard to be seen as a profession which is in line with debates about work being undertaken (Liaschenko and Fisher 1999, Liaschenko and Peters 2004, Hoff 2001). Arguably, the model proposed by Liaschenko and Fisher (1999) is more in line with a patient centred NHS apparent in recent policy (DH 2006), particularly the discussion of person. As such, the choice of Liaschenko as a theoretical framework would seem appropriate. Turner (1995) explores knowledge bases offered by 'paramedicals' as a means of increasing their share of the market of healthcare (Turner 1995: 139). The knowledge of professionals is now viewed in a different light with the emphasis on partnership working of professionals with patients in order to increase self-management capabilities. As such, claiming knowledge as power could be seen as argument which weakens professions and strengthens the division of labour to include patients and carers.

Interactional theorists, such as Abbott (1988) who explores division of labour through his work on professional jurisdiction suggest that professions such as medicine have served their own interests rather than being altruistic in nature. By developing a system of self-regulation, their status has been maintained which has necessitated excluding others such as nursing.

The debates noted here around professionalization and division of labour could have provided a theoretical basis for my thesis. Had my research question focussed more around nursing as a profession, or division of labour rather than embedding of a new role, then the usefulness of either Friedson, Larson, Abbot or Turner's work, or a combination would have provided a useful lens.

The ideas of autonomy espoused by Friedson (1970) and Larson (1977) could also have been useful as my thesis explores the role of community matrons, which is an autonomous role in many ways. Overall, using a sociological lens could have worked, but using Liaschenko's lens firmly roots the thesis in a clinical nursing sphere and that was an important factor in my decision making. Additionally, while the sociological theories explore the roles of various single professional groups, I contend that this does not allow for inter professional and inter agency perspectives. As I consider these factors are critical in a community nursing setting and therefore encompass the role of community matrons, I argue that Liaschenko's (1997) boundary work does offer this perspective and makes the use of Liaschenko as a theoretical framework that is most appropriate for my doctoral work.

Other potentially useful frameworks were highlighted from a social science background. Worthy of mention are May et al.'s (2009) Normalisation Process Theory (NPT) and Rogers's original 1962 work Diffusion of Innovations (2003) (which was an area further examined through a systematic literature review by Greenhalgh et al. (2004).

May and Finch (2010) state that NPT offers an explanation of the work of implementation, embedding and integration. It focuses on the input by both individuals and groups and looking at what people actually do and how they work. As such it is a theory of action. May et al. (2009) note this as the aspect which distinguishes NPT from other robust social theories which seek to explain individual differences in attitudes to new practices. Examples of these social theories include the theory of planned behaviour (Ajzen 1985); the flow of innovations through social networks eg. Diffusion of innovations (Rogers 2003) and reciprocal interactions between people and changes eg. actor network theory (Latour 2005).

NPT seeks to explain routine embedding by referring to four generative mechanisms: coherence, cognitive participation, collective action and reflexive monitoring (May and Finch 2010). Coherence defines and organises the components of a practice; cognitive participation defines and organises the people implicated in a complex intervention; collective action considers the enacting of a practice and reflexive monitoring makes an assessment on the outcome of a practice (May and Finch 2010). Using NPT as a research and development tool enables researchers to understand why some innovations in practice become a routine part of service delivery and why some do not (Finch and May 2009). In light of this, using NPT could have offered a suitable theoretical base for examining the embedding of the community matron role. However, although it could have been easily transferrable to nursing, I chose Liaschenko as a theoretical framework, because I wanted to extend some of her ideas around invisibility and boundary work in relation to forming a language which better described what nurses, and here community matrons, do.

In a similar vein, though different in that NPT is an action theory as noted by May et al. (2009) the Diffusion of Innovations theory (Rogers 2003) sought to explain how, why and at what rate new ideas and technology spread through organisations. Diffusion is noted by Rogers (1962) as the means by which an innovation is communicated through channels, in a time period to members of a social or work network. For Rogers (1962) it is these four influences on the way an innovation spreads that are critical. Human capital, so the amount of investment in the innovation by staff, is another factor in the success or otherwise (Rogers 1962). Terminology associated with this theory is widely used in relation to adopters of innovation. It comprises innovators themselves, early adopters, the early majority, late adopters and laggards (Rogers 2003)._

Following a systematic review of the literature on diffusion of service innovations, Greenhalgh et al. (2004) described a continuum of the different conceptual and theoretical bases. These comprised: 'let it happen', so an unpredictable uncertain and emergent programme; 'help it happen', so negotiated and enabled and 'make it happen', so scientific, programmed and planned (Greenhalgh et al. 2004: 593). A different research question and focus would have been needed, in my view, to have

usefully implemented this theory. As NPT and 'Diffusion of Innovation' theories are described as a theories of action, they may have been better suited to an action research methodology and I particularly felt that a mixed methods approach would suit my research question.

Although, I noted that where the sociological theories did not consider inter professional and inter agency working, NPT and diffusion theory do consider the importance of networks and as such could have been useful in capturing aspects associated with inter professional and inter agency work. However, the perspectives of NPT and diffusion do not account for gender and healthcare politics. Although, I have not favoured the gendered perspective laid out by Davies (1995), I consider that Liaschenko does explore healthcare politics in relation to inter professional and inter agency working by exploring boundary work which in turn uncovers issues related to visibility of nursing and therefore embedding. By further exploring nursing in terms of case, patient and person (Liaschenko and Fisher 1999) it sought to capture the relationship of nursing to people, to patients and to other networks of professionals which is a significant factor in the work of community nurses and especially for this work, community matrons.

Liaschenko's work (1995, 1997 and with Fisher 1999) had a resonance with me particularly because of the findings which emerged from the parent project. I wanted to explore this further in a UK context utilising the community matron example. That Liaschenko's work offered an empirical base from nursing, including community nursing was important to me.

Having offered a theoretical framework for my study, this chapter concludes by drawing together decisions made about my thesis.

3.3 Thesis Focus

Having given the background (chapter 1) on which this thesis is built, and explored the literature in relation to case management and invisibility (chapter 2), I noted that despite case management offering a framework for community matrons to work in, this did not appear to result in a better understanding and greater knowledge of their role by professions working alongside them. Additionally, much of the literature on invisibility of nursing referred to nurses working in teams, whether that is in hospital settings or

community. There was scant evidence pertaining to autonomous community roles, such as that of community matron. With these gaps in the literature noted the following research question was formulated

What factors affect embedding of the nursing role of community matron?

The aim is to undertake a mixed methodology study of the factors that have affected embedding of the community matron role in 3 geographical areas.



Figure 8: Overview of layers of enquiry within the thesis

Objectives of the study are:

- To examine how the role of community matron is operationalised through case management
- To consider how the role and service design has been embedded in light of policy initiatives and the emphasis on reduction in admissions to hospital

- To explore aspects of the role and provision of care which are valued by the community matrons, patients and family carers, managers, GPs and former commissioners.
- To examine factors which impact on embedding of the role of community matron from the perspective of the community matrons
- To consider whether using the lens of Liaschenko and her reports of nursing work being invisible help to explore embedding of the current role of community matron

The thesis has re-examined data collected for the parent project, and then incorporated new data to further develop the findings. The knowledge gaps and research steps are shown in figure 9. Details of the parent project and methods used are described in chapter 5, section 5.2. The stages were as follows:

1) This was a mixed methods study which encompassed a re-examination of the effectiveness of community matrons on hospital admissions using PARR ++ data.

2) In addition, the qualitative data derived from interviews with patients, family carers and community matrons in area 1 has been re-explored where participants have re-consented to this. Further data has been collected from similar participant groups in new geographical areas: area 2 and area 3. The exploration of these data is in relation to the invisibility of aspects of nursing and in relation to boundary work undertaken by community matrons, as discussed in papers by Liaschenko (1995, 1997), Liaschenko and Fisher (1999) and Liaschenko and Peter (2004), as well as by other writers on the subject.

3) In order to explore how decisions are made in relation to commissioning nursing roles, namely that of community matron, and how local contexts impact the embedding of such roles, former commissioners were interviewed in an additional two areas. Some GP views of their roles in relation to possible commissioning nursing roles in the future have been explored.

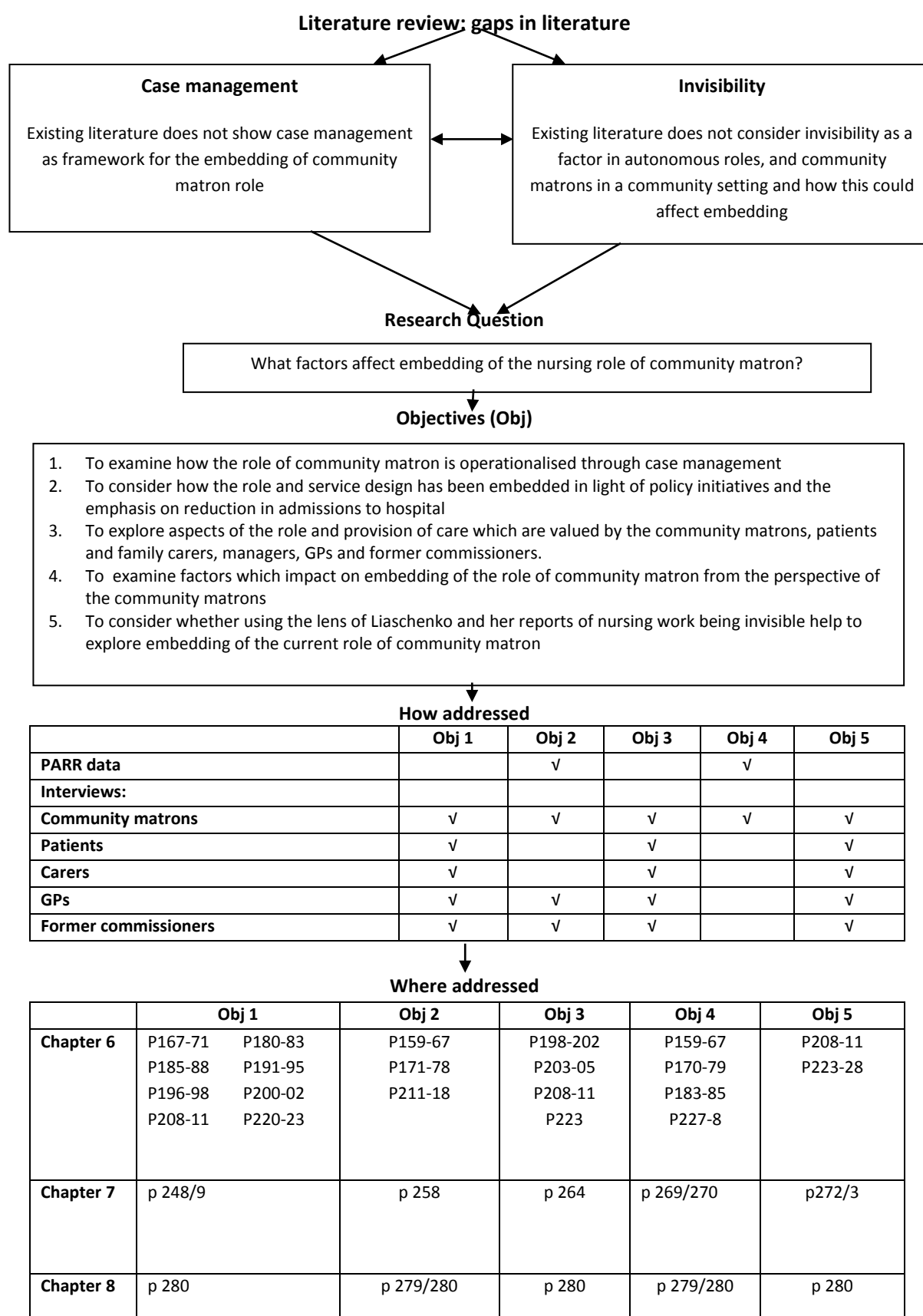


Figure 9 Knowledge gap and research steps

As part of the doctoral process, additional qualitative data were collected from a two further areas, in addition to area 1 which was the site of the parent project. Additional sites were used to explore the *a priori* findings within a different geographical context and also where the role of community matron had been set up differently. The choice of areas 2 and 3 was purposive. Knowing the areas, I considered that the choice provided greater depth for the study because the areas varied. This variation was city versus rural, but also different in terms of economic and social make-up of the populations. In addition, I knew that the make-up of the community matron service in these 3 areas had changed from the original concept at the inception of the service. By exploring 3 different service models (which can be found in table 27, section 6.1), I consider that the findings of my thesis may offer a resonance with a greater number of other areas throughout England. The context, in terms of economic and social make-up is presented next.

This study originated in a single inner city area in the Midlands (area 1, see section 5.2). The new areas are 'area 2' which comprises a city in the Midlands, whilst 'area 3' is a largely more rural setting, again in the Midlands. The service delivery model in area 1 was briefly described in section 3.3. In area 2, the service delivery model for community matrons was again based around autonomous practitioners working 9-5, Monday to Friday. Changes were made to place a community matron in 'fast response', similar to intermediate care with a focus on preventing emergency hospital admission. This increased the working hours from 9-5 to 8-8 and included the availability of a community matron at weekends. In area 3, the community matron service was set up as an autonomous role, Monday to Friday, 9-5. The introduction of a virtual ward (VW) in some parts of area 3 meant that two models operate. The term 'virtual' meant patients being cared for in their own homes, rather than in a formal hospital building, with care by a group of health care professionals (GP, therapists, nursing) according to need, which mirrors care in a hospital. The VW included skill mix within the nursing team and the ability to discharge patients from the VW back to traditional GP care once an exacerbation had settled. The community matron leads and assesses patients as part of this model.

Area 1 sits amongst the 10% most deprived areas in England when measured on lower super output areas (LSOA) (Social Disadvantage Research Centre 2010). In these indices of deprivation, a broader consideration of factors other than income alone and including general lack of resources and opportunities are counted.

Area 2 fairs slightly better, falling within the 20% most deprived in England when examined using LSOA.

Area 3 offers a contrast which ranks it in the 20% least deprived areas in England, although pockets of deprivation do exist within nine areas measured at the super output level all in the north of the area (Linnane 2011).

Prevalence and impact of long-term conditions is known to be affected by deprivation and social class, so contextually this is important to understand across the three areas of study. People from lower socio-economic groups have an increased risk of developing a long-term condition. Compared to social class I, people in social class V have 60% higher prevalence of long term conditions and 30% higher severity of conditions, though this varies significantly by condition (DH 2012a). All three areas offer a distinct ethnic mix as shown in the table (table 11):

Ethnicity	Area 1	Area 2	Area 3	England
White British	32.8	74.1	92.8	83.6
White other	5.0	5.7	2.8	4.6
White mixed	4.4	2.2	0.7	1.7
Asian or British Asian	41.0	12.1	2.8	5.7
Black or British Black	13.6	3.3	0.4	2.8
Chinese/Other	2.3	2.6	0.4	1.5

Table 11: Ethnic mix of 3 study areas

Although issues associated with ethnicity are not directly explored as part of my doctoral study, I felt the context was important and some issues are raised within the data which are directly associated with cultural mix in area 1 in particular. In order to examine issues it would seem pertinent to explore how and why the role of community matron was deemed important in 2004.

Although Liaschenko appears to take a feminist perspective in examining these themes, this is not my focus. Indeed this viewpoint is less important to me than exploring issues of embedding and how the role is seen and how the work undertaken as part of the role is viewed. I have considered that power which emanates from a medical hierarchy could be a reason why embedding is poor. Indeed, prior to the changes made by the present coalition government, power formerly may also have emanated from commissioners and the Strategic Health Authorities. Drennan et al. (2011) do not consider power to be an issue in why this role has been slow to embed. It could be argued that the role of community matron is not traditional in the sense of a nursing role under the power of medics, but perhaps more like the role of doctors themselves, whereby they are autonomous practitioners under the power of NHS managers. With the changes in commissioning, doctors will regain the ascendancy over NHS managers and so the situation may change again. As such, issues of power are acknowledged in my thesis, but the stronger emphasis is a re-evaluation of nursing and considering what constitutes nursing through the role of community matron. That much of nursing is not seen and is threatened by policy which appears to applaud quality and patient centred approach whilst taking note of more easily measurable outcomes and cost is explored. Over the last three years I have been immersed in research with community nurses, predominantly matrons and with their patients and have seen the extreme lengths that individual nurses go to in order to ensure that the quality of a patient's life is the best it can be.

So, my theoretical lens is about the implications of the invisibility of nursing in relation to nurses and their patients who have long-term conditions. The work so far has been applied research which forms a part of my role as senior lecturer in primary health care and pathway lead for long-term conditions in the Department of Nursing. In some ways

it also considers the status of working with an older population. In providing this information readers have the chance to understand the author's reflexivity within the work (Polit and Beck 2004). By showing reflexivity, particularly in relation to the qualitative aspect the author acknowledges her role as influencing the research in some way (Polit and Beck 2004). This will be explored in greater depth later in the thesis (section 4.4).

3.4 Chapter Summary

This chapter has introduced the work of Joan Liaschenko in relation to work which has explored nursing as invisible. As a result of this the chapter concluded with the thesis focus and the researcher's theoretical lens.

3.5 Operationalising the research focus

Having set out background and context in chapter 1, chapter 2 presented a literature review on 2 concepts which arose in chapter 1, namely case management and invisibility of nursing. Chapter 3 considered the work of Joan Liaschenko with a rationale for her work (and that of Anastasia Fisher) as a theoretical framework. In turn, consideration of other possible frameworks was undertaken. The research focus explores case management and invisibility as factors affecting embedding of the community matron role. This is done using the work of Liaschenko and Liaschenko and Fisher as a theoretical base. Chapter 4 offers an insight into how I made choices in relation to research methodology. It examines positivism, post-positivism, interpretivism/constructivism, paradigm wars and mixed methods. It explores available research designs of priority sequence models. My own reflexivity and stance within the project is presented. It therefore offers the reader an understanding of my decision making in undertaking a mixed methods study: QUAL quan. Following on, chapter 5 provides details of methods used and how these decisions were made. Qualitatively semi structured interviews and audio diaries were used with participants who volunteered or were purposefully sought. The quantitative aspect of the study involved the use of PARR data sets and this is explained. Ethical considerations are considered, study rigour, issues pertaining to access and consent, data analysis methods and study

limitations are provided. Chapter 6 presents the study findings. The QUAL quan aspects have been presented as part of a whole. An overview of themes can be found in appendix 14 for a brief overview. Chapter 7 offers interpretation and discussion of the findings. At this juncture, the work is linked back to that of Liaschenko and Fisher (1999) pulling the thesis together. A diagrammatic representation can be found in appendix 15. Finally in chapter 8, conclusions and recommendations for policy, practice, education and research are made.

Chapter 4: Methodology

4.1 Introduction

For researchers who favour mixed methodologies, the research problem is a central tenet in the decision to do so. In providing a rationale for the use of a mixed methods approach, I will use this chapter to explore the historical context through which the current position of research paradigms has been established. Additionally, rationale for the use of first person in my work is discussed in section 4.4.

Paradigm, as a term commonly used in research, is attributed as being first used by Kuhn (1970) and along with a great deal of terminology associated with research has been the subject of much debate. In his body of work, Kuhn (1962, 1970) established the idea of paradigms which competed against each other in periods of 'revolutionary science'. Positivist and interpretivist had to co-exist, as well as the idea that paradigms could shift. This latter idea is seen through the introduction of mixed methods research. Positivist (generally associated with quantitative) and interpretivist (generally associated with qualitative) paradigms will be examined alongside the debates surrounding the 'paradigm wars' (Gage 1989) and the establishment of a third paradigm, that of mixed methods.

This will then be considered in relation to the research question and the complexities of exploring issues surrounding long-term conditions and underpin the methodology on which methods choices are based.

4.2 Research Theory

Guba and Lincoln (1989) describe paradigms as world views. Depending on a researcher's world view or knowledge claim (Creswell 2003), certain assumptions are made as a result. These assumptions can be considered in the following context: ontology, epistemology, axiology, rhetoric and methodology. Creswell (2003) places the following meanings to each term:

Term	Meaning
Ontology	What is knowledge
Epistemology	How we know about knowledge (the relationship between researcher and subject being studied)
Axiology	The values which go into the study
Rhetoric	How it is written about
Methodology	Processes for studying it

Table 12: Terminology of World Views (adapted from Creswell 2003)

Creswell acknowledges the work of Crotty (1998) in the framework tabled above as an extension of Crotty's own framework which comprised epistemology, theoretical perspective, methodology and methods. Examination of the history of research shows how ideas have developed and expanded over time.

4.21 Positivist Views

Positivism was the dominant paradigm of the 19th and much of the 20th century. Polit and Beck (2004) describe positivism as:

'The traditional paradigm underlying the scientific approach, which assumes that there is a fixed, orderly reality that can be objectively studied' (pg 728)

In linking positivism with research theory, Polit and Beck (2004) give the major assumptions as:

Assumption	Positivist Paradigm
Ontology	Reality exists in a real world
Epistemology	Independence is maintained between researcher and subject of study, so findings are not influenced by the researcher
Axiology	Objectivity is key and values and biases are actively considered and accounted for

Assumption	Positivist Paradigm
Methodology	<ul style="list-style-type: none"> -deductive processes -control over context -emphasis on measured information & statistical analysis -aims to generalise

Table 13: Positivist world views (Adapted from Polit and Beck 2004)

In seeking knowledge, positivists aim to be objective in order to seek reality. In so doing, they hold their own beliefs and values back, so as not to contaminate the process (Polit and Beck 2004). A positivist approach is often, though not always, undertaken in a laboratory setting. Of the early scholars, the views of Comte (1798-1857) remain important. Hughes and Sharrock (1997) note one of Comte's most influential assumptions was that society, including values and beliefs, could be examined in the same logical way as natural sciences. Determinism, or cause and effect is a belief held by positivists, as is a hypothetical-deductive approach which means that hypotheses are put to the test through deduction to seek a true version of events (Parahoo 2006). This research design is associated with quantitative research, where phenomena to be studied lend themselves to exact measurement and are quantifiable, often involving rigorous and controlled design (Polit and Beck 2004). Clinical trials, and notably randomised controlled trials are the most common form of quantitative research undertaken in the field of health.

Methodology for a positivist approach would require an experimental design, following a systematic path, often comprising a control group in order to compare the effects of an intervention. The interest is in results which are generalisable across large populations. In considering long-term conditions, the introduction of new insulin would be highly suitable for a positivist study, likely a randomised controlled trial, where suitable patients with similar characteristics could be sought, informed consent gained and the sample randomly assigned to either the new insulin or to remain on existing treatment. As all subjects would continue to receive treatment, the study is ethical, subject to other

considerations, also. The randomised controlled trial is considered to be the gold standard when assessing how effective a particular intervention is (Centre for Reviews and Dissemination 2001).

Later in this chapter, I will return to the positivist paradigm when explaining the rationale for underpinning theories in my study. For now, the focus of the chapter moves to post-positivism.

4.22 Post-positivism

Early in the 20th century, there was a shift from positivism to post-positivism with a realisation that the idea of reality which took no account of the experience of people was 'naive' (Parahoo 2006). The idea that social phenomena could be explained by universal laws was put aside, because social events could not be explained in the same way and with the same certainty as physical events could be explained by natural scientists (Parahoo 2006). Positivists saw social facts as only those which could be observed and monitored through human senses of touch, smell, taste, sight and hearing. In reconsidering the limitations of positivism, post-positivists maintain the importance of reality, but consider reality in terms of a critical examination of reality as distinct from the naive interpretation of positivists. This subtle, yet important shift opened up the opportunity of studying self report. However, an important distinction remained in that self report had to be considered objective by the use of valid and reliable tools, which remain central in quantitative research (Phillips and Burbules 2000).

Reichardt and Rallis (1994) state the importance of understanding the clear distinctions between positivist and post-positivists. Their concern is that use of terms can lead to confusion and that, in particular, the labelling of the quantitative paradigm as positivist may lead to a blurring of positivist thinking and post-positivist, when, in fact, positivism has not been used since the Second World War and post-positivism is the contemporary stance for quantitative research.

The assumptions associated with post-positivism are tabled below:

Assumption	Post-positivist
Ontology	Critical realism: external reality which is understood as imperfect
Epistemology	Modified dualism (dualism = objective point of view)
Axiology	Values in research but these can be controlled
Methodology	-Primarily quantitative -hypothetical-deductive -internal validity important

Table 14: Post-positivist World Views (Adapted from Teddlie and Tashakkori 2009)

Having explored aspects of post-positivism, I consider the ideas behind interpretivism and constructivism which underpin the qualitative tradition.

4.23 Interpretivism/ Constructivism

Again, terminologies vary and Lincoln and Guba (1989) call the non-positivist view naturalistic inquiry. The idea of social construction as a term and a platform for advancing thinking from the positivist and post-positivist traditions is also used (Berger and Luckman 1967). Parahoo (2006) concludes that it is possible for interpretivists to share the idea of a 'critical' reality with post-positivists, because interpretivist methods can produce findings which mirror reality. However, interpretivism can be subdivided and constructivists would consider ideas of 'multiple realities' and would therefore be positioned further from post-positivists. Such thinking lends itself to the idea of a continuum on which the different paradigms of research sit and will be examined in greater detail in section 4.5.

So, this paradigm does not see reality as fixed, but rather a construction of those taking part in the research. The researcher is seen as being an integral part of the research, but as such, must declare their position within the process. The following assumptions are made in relation to research theory:

Assumptions	Naturalistic Paradigm
Ontology	<p>There are multiple realities. Subjectivity is important.</p> <p>Realities are constructed by people.</p>
Epistemology	The researcher is a part of the research and findings come from the interaction between researcher and participants.
Axiology	Subjectivity and values are acceptable and expected
Methodology	<p>-inductive process</p> <p>-interpretations grow out of participant experiences</p> <p>-findings have to be considered in context.</p> <p>-seeks patterns rather than generalisability</p>

Table 15: Interpretivist World Views (Adapted from Polit and Beck 2004)

In terms of research design, this research is often referred to as qualitative, whereby a phenomenon is typically investigated in-depth by collecting rich narrative data, with the study design remaining flexible (Polit and Beck 2004). Under the umbrella term of qualitative research, there are many 'pure' methodologies. Some of these are: ethnography, phenomenology, grounded theory. Smith (1994) places qualitative writers into two camps: theoretical and practical, where she claims much time is spent on clarification of underpinning philosophies and the examination of approach and method 'fit', with particular attention to those philosophies which are deemed 'too close' to positivism to be of use. It is not clear from Smith's (1994) debate whether she perceives the theoretical camp to be 'pure' and the 'practical' camp as pragmatic. Other authors have noted a shift away from 'pure' methodologies. When comparing methods and strategies utilised in qualitative research and published in Qualitative Health Research and other qualitative research journals, Shin et al. (2009) found that between 1999 and

2007, 95 out of 135 published qualitative research studies did not credit any one particular research methodology. Thus, even within the interpretivist/constructivist paradigm, there are debates.

Having examined the major protagonists in research terms, I will now explore the paradigm wars and how such debate resulted in the newest contender, pragmatism as a theoretical underpinning for mixed methods.

4.24 Paradigm Wars

There are critics of quantitative research philosophy and also of qualitative. Critics of quantitative research highlight that empirical observations only provide a partial insight into human phenomena (Parahoo 2006). Authors, such as Hughes and Sharrock (1997), note that 'science', (or positivism) occupies a privileged place in human thought about reality, although they disagree that it should. However, as evidence based practice became common place, examination of evidence took place in order to ensure those using the evidence were able to make judgements on it. From this, hierarchies of evidence were produced. One such hierarchy, Mazurek and Fineout-Overholt (2005) contains seven levels, level 1 seen as the highest. Levels 1-4 are associated with a quantitative study design, and level 5 being the first mention of a qualitative study. Taken at face value, it can be seen where research with an underpinning positivist or postpositivist philosophy gets its advantage. That a quantitative design provides objectivity, and results that can be generalized make it important in healthcare. Predictive models, for example, those which seek to predict development of pressure sores, will have examined causal relationships across large numbers of individuals in an objective way and be an important means of assisting nurses to make judgements based on evidence in order to provide quality care to patients (Dealey 1999). Having a critical understanding of research is important because, as Bradley and Field (1995) note, not all that is measurable is of value, and not all that is of value can be measured.

Critics of qualitative research state that it is anecdotal, unscientific and not generalisable (Parahoo 2006). Smith (1994) states that ignoring numbers in qualitative evaluations leads to '*journalistic storytelling*' (42:1994).

Parahoo (2006) notes that some of the criticisms of both paradigms fall below an accepted level of debate. Some extremes are noted by Barber (1996) who reports the portrayal of quantitative research as oppressive and evil whilst lauding qualitative as noble, good and empowering. Such simplistic description appears to lack any degree of understanding of research philosophy. It is possible to argue that both positivists and constructivists in the fields of healthcare seek to improve the lot of individuals suffering ill health and associated difficulties. That problems can be approached from different viewpoints is not a worthy excuse to demonise the other. Kuhn (1970) implies just this when he suggests that competing paradigms may exist simultaneously. For Kuhn (1970), the coexistence in periods of revolutionary science is only temporary until the alternate paradigm gains dominance. Brewer and Hunter (1989) concur by explaining in social sciences there is virtually no major area which is studied exclusively within one method.

In considering positivism and the naturalist paradigm in their purist forms, Lincoln and Guba (1985) made the following distinctions between the two paradigms: positivists believe in a single reality whilst naturalists believe in multiple constructed realities; positivists believe that the knower and known are independent whilst naturalists believe they are inseparable; positivists believe that inquiry is value free, whilst naturalists believe it is value-bound; positivists believe that time- and context-free generalizations are possible and naturalists do not; positivists believe that there are real causes that are temporarily precedent to or simultaneous with events, whilst naturalists believe it is impossible to distinguish cause and effect (Lincoln and Guba 1985). In addition to these widely held values, a 6th distinction was noted: positivists believe in deductive logic arguing from the general to the particular whilst naturalists believe in inductive logic whereby the emphasis is on moving from the particular to the general (Patton 1990).

In acknowledging the different philosophies of both positivist and naturalist schools, Lincoln and Guba (1985) note that it is not possible to join the two. This lends weight to the argument suggested by Smith (1983) stating that researchers who try to amalgamate the two are 'doomed to failure', because of the major philosophical differences. Continuing this opposition to calls for unification, Smith and Heshusius (1986) continue to contend that the philosophies are incompatible. This work became known as the Incompatibility Thesis and is important work in gaining understanding of key

antagonists. In practice, this attempt to close down debate actually resulted in further discussions.

In 1988, Howe wrote about a third paradigm, that of pragmatism. This work became known as the Compatibility Thesis and underpins the movement of mixed methods. Tashakkori and Teddlie (1998) refer to the authors (Howe 1988, Reichardt and Rallis 1994) who attempted to unify the paradigms as pacifists, thus adding to the analogy of war commonly associated with the paradigm debate. In turn the pacifists become pragmatists because of their use of whichever philosophical or methodological approach works to answer the question: hence the term paradigm relativism.

Further efforts to reconcile the paradigms were undertaken by Reichardt and Rallis (1994), who sought to answer the concerns raised by Lincoln and Guba (1985) around incompatibility. Reichardt and Rallis (1994) consider 5 areas: theory-ladenness of facts; fallibility of knowledge; under-determination of theory by fact; value ladenness of inquiry and the nature of reality.

To consider each argument in turn, the theory-ladenness of facts concerns the existing knowledge which is held by a researcher, which can influence what is observed.

Reichardt and Rallis (1994) contend that this is well accepted in post-positivism. Yet Guba and Lincoln (1989) consider the theory-ladenness of facts to be a central aspect of qualitative research and not of the quantitative paradigm. In noting the similarities between the paradigms in this matter, Reichardt and Rallis conclude that this aspect is not incompatible.

A major distinction between positivism and post-positivism is that followers of the latter consider knowledge to be fallible. Cook and Campbell (1979 in Reichardt and Rallis 1994) noted that experiments only probe rather than prove and that an adequate hypothesis can survive multiple probes but can also be displaced at any time by 'new knowledge'. For Guba and Lincoln (1989) the quantitative paradigm implies that knowledge is definitive and that truth is absolute. This would appear to be an argument for positivism as opposed to post-positivism and therefore arguably not a contemporary viewpoint as noted above (Reichardt and Rallis 1994). In promoting the qualitative paradigm, Guba and Lincoln (1989) extol that qualitative knowledge is subject to continuous change. In

conclusion, Reichardt and Rallis (1994) consider that both sides accept that knowledge is fallible, so again the incompatibility is inconsistent.

The 'under-determination of fact' (Guba and Lincoln 1989) states that all data can be explained by different theories. For Guba and Lincoln (1989) this is key in the qualitative paradigm, but not in the quantitative paradigm. Reichardt and Rallis (1994) have trawled the quantitative literature to find examples which dispel this. Again Cook and Campbell (1979), in examining hypotheses, consider that the number of potential hypotheses available to displace another is probably infinite, which could be translated to mean that data can be explained by different theories. As such Reichardt and Rallis (1994) take this as an example that shows compatibility rather than incompatibility.

The value-ladenness of inquiry is another contested point, but again the move from positivism to post-positivism allowed for values of researchers to be accepted, albeit with some degree of associated control.

When considering the nature of reality Guba and Lincoln (1989) contend that realities are not objectively 'out there'. For Reichardt and Rallis (1994) there is evidence that those in both the quantitative and qualitative paradigms accept that there is a realist perspective and as such the incompatibility is negated.

In addition, Datta (1994) writing about the discipline of evaluation, has given 5 reasons for the co-existence of post-positivism and constructivism. She concludes that both paradigms have been used for a considerable amount of time; that many evaluators and researchers have suggested using both paradigms; funders support both paradigms; both paradigms have influenced policy and much has been taught by both paradigms.

Seemingly, this would conclude the 'wars', but debate continues, albeit that the debate may be considered to have matured from early crude characterisations. Many researchers accept the idea of a research continuum when considering philosophies of research, rather than a dichotomy (Teddle and Tashakkori 2009). As such, they consider the position of pragmatists to form a middle way on the continuum between positivism at one pole and constructivism at the other, and introduce the model as QUAL-MM-QUAN. This provides an extension to earlier similar ideas. The idea of a dichotomy, with

positivist and interpretivist ideas being opposites, had been challenged previously by Hammersley (1992) in Parahoo (2006:88). As such, Paley (2000) argues that qualitative and quantitative refer to different tools used rather than being different types of research. With this in mind, perhaps Strickland's (1993) idea of a continuum fits well, albeit that qualitative and quantitative research generally lie at opposite ends of the continuum.

From my perspective, as a nurse and educator, debate is a good thing. Health researchers are usually attempting to improve health outcomes whether that be through the development of new drugs or by increasing knowledge and understanding of patients and staff experiences. My view is that the problem should drive the research and therefore mixed methods offers a greater ability for this to take place and as such the debate and creation of a middle way should be seen as beneficial if used in appropriate circumstances. That interpretivism and post-positivism still have their place too remains important if the research issue is to drive the methodology. As such, the methods chosen for this research are in line with my paradigm position and will be explored in the methods chapter.

Having established a place on the research continuum for pragmatism, I will now consider key aspects of pragmatism.

4.25 Pragmatism

As with positivism, post-positivism and the interpretivist/constructivist sections above, this section will describe key features of pragmatism as a knowledge claim (Creswell 2003). Perhaps the key phrase which is associated with pragmatism comes from Patton (1990) '*what works*'. In other words the focus of pragmatism is on finding the best means possible to find a solution to a problem. The finding of a solution takes higher priority than the methodology. So pragmatism is not bound to any particular research philosophy, but instead allows freedom of choice in methodology and methods employed. In being problem-centred, pragmatism has a strong orientation to 'real world' practice (Creswell 2003). As such pragmatism may seem an obvious choice for applied research. Applied research is defined by the United Nations Population Fund (UNPF) (2004) as:

‘a type of research conducted on the basis of the assumptions that human and societal problems can be solved with knowledge.’ (p2)

In another exploration of applied research by Thunhurst and Randall (2010), it is described as eclectic in the methods used, but that does not make applied research atheoretical, but instead, theoretically conscious rather than theoretically driven. According to Cherryholmes (1992: 14), in ontological terms, pragmatists agree with positivists and post-positivists on the existence of a reality which exists outside of the human mind, but dispute that truth regarding reality can actually be determined. In her 1994 work, Cherryholmes goes on to define the beliefs of pragmatists in relation to reality, causality and objectivity; that they are context dependent and change, not always in predictable ways. Johnson and Onwuegbuzie (2004) consider some characteristics of pragmatism and conclude that the reality and influence of human experience as felt and actioned by individuals is held in high regard and, as such, knowledge is based on both individual constructions as well as on the reality of the world in which individuals are a part.

Assumptions associated with pragmatism are as follows:

Assumptions	Pragmatism
Ontology	Diverse viewpoints regarding social realities. Important that researchers’ own view points are clear
Epistemology	Both objective and subjective views are used depending on the stage of the research
Axiology	Values are important in interpretation
Methodology	<ul style="list-style-type: none">-Associated with qualitative and quantitative are acceptable in pragmatic approach-Both inductive and hypothetical- deductive- Values important in interpreting results-Both internal validity and credibility important

Table 16: Pragmatic World Views (Adapted from Teddlie and Tashakkori 2009)

Many authors think that pragmatism is a 'good fit' as a paradigm which underpins the mixed methods approach to research. They include: Howe (1988), Tashakkori and Teddlie (1998), Johnson and Onwuegbuzie (2004) and Morgan (2007). However, Mertens (2003) considers that a transformative perspective is a better 'fit' with mixed methods. A transformative perspective places central importance on marginalised groups and their experiences. Teddlie and Tashakkori (2009) note the major difference between pragmatism and transformatism is at the level of axiology, where in pragmatic research the research is undertaken within the value system of the researcher and is based on answering questions proposed by the researchers. Indeed, Johnson and Onwuegbuzie (2004) consider that pragmatism takes an approach which is specifically value oriented, in line with cultural values, and specifically names democracy, freedom, equality and progress. However for the critics of the value system of pragmatism, the statement about values is too vague and fails to really establish 'what values' and 'whose values' (Mertens 2003). Lipscomb (2008) critiques pragmatism as simplistic and a poorly practised attempt to underpin the use of mixed methods. In his later work, Mertens (2005) put forward the idea that using a clear research agenda which allowed the values and viewpoint of marginal groups would be a better axiological stance for mixed methods. Having considered the argument, Teddlie and Tashakkori (2009) consider that it is acceptable for both world views (pragmatism and transformatism) to underpin mixed methods. This would lend itself to the thesis of multiple paradigms, whereby more than one paradigm idea can support mixed methods research. Creswell (2003) supports the view of multiple paradigms. In presenting six models of mixed method design, Creswell (2003) considered that a single paradigm did not underpin all. The argument about underpinning theory for mixed methods is further challenged by Mason (2006) who actively argues that a constructivist epistemology can make a very good 'starting point' for mixed methods research.

Whichever world view mixed method researchers choose to take, is perhaps less important than the fact that they clearly state the underpinning theory for the research; without clear terminology, Datta (1994:59) states that mixed methods can be accused of being 'mixed up methods', which may give weight to critics' arguments.

In order to understand and appreciate the use of mixed methods research, Johnson and Onwuegbuzie (2004) stress the importance of gaining a clear understanding of the major characteristics which underpin both quantitative and qualitative research. Having considered these, above and in also considering the place of pragmatism as an underpinning theory of mixed methods research, I move the chapter on to explore how mixed methods research is presented in the literature.

4.26 Exploration of Mixed Methods Research

In the previous section, I sought out key aspects of research disciplines. Understanding the strengths and weaknesses of qualitative and quantitative research is key to mixing strategies according to Johnson and Turner (2003), who call this the ‘fundamental principle of mixed research’. Stating an underlying philosophy in mixed methods research is important as mixed methods research is not inherently good practice unless underlying philosophies are understood (Johnson and Onwuegbuzie 2004). Broad statements litter the literature about advantages of using mixed methods. These include: flexible and holistic (Andrew and Halcomb 2006/7), seeking a more comprehensive picture (Clarke 2009), gives accounts which are more complete (Bryman 1988), allows flexibility (Sandelowski 2000) and by mixing approaches the contribution is greater than using a single approach (Johnstone 2004). Giddings (2006) states that in using mixed methods, a critical approach should be taken, as it is not enough to say that using mixed methods ‘gives the best of both worlds’. Giddings (2006) goes further and actively criticises nursing research which uses mixed methods as failing to show theoretical and methodological consideration. Greene and Carracelli (2003) note that research in general, not just in nursing, is not good at acknowledging the importance of paradigm issues. Other authors concur about the importance of showing consideration of underpinning theory, with Clarke (2009) emphasising the need to show how methodological separation occurs and Shaw et al. (2010) adds that mixed-methods research must be thorough in design and research conduct, although it might be argued that this is equally important for research undertaken in a single approach of quantitative or qualitative. An example of a paper which is packed with theoretical and methodological thinking is presented by Johnstone (2004). It could be considered that there is an indication of a poor theoretical basis for mixed methods, but I have

highlighted in the chapter so far, evidence is present but often authors do not make use of it.

Attempts have been made to ensure that mixed-methods research is accepted and cannot be criticised for its lack of theoretical underpinning. In Giddings article (2006) she quotes Morgan as stating that ontological and epistemological concerns should not lead the research process in mixed-methods research, but rather the practical problem which is to be addressed is central in importance. This confirms Patton's thoughts (1990). In his 1998 paper, Morgan states that designing mixed-methods research to an appropriate set of motivations is important and it may be possible to take motivations as stemming from the world views of the researcher. Rather than simply stating that mixing methods allows the researcher deeper interpretation or richer data, Miller and Fredericks (2006) consider that a greater degree of internal logic on the part of the researcher is required to back up seemingly vague statements.

Morse (1996) has also criticised mixed-methods as implying that qualitative research is not complete in its own right and needs to be backed up by quantitative examination of the same issue, with the latter continuing to hold the power base as 'true scientific research'. Sale (2002) concurs by considering it a misconception that qualitative research is seen as being legitimised by the use of quantitative methods in the same research question. Morse refutes any such claim seeing movement from qualitative to quantitative as acceptable providing it was part of the original research goal and that in triangulating data from mixing methods states findings can be essential, important and powerful.

In exploring mixed-methods in health care further, several authors are positive about the contribution which such a research design allows. Johnstone (2004) contends that the depth of knowledge uncovered by using mixed-methods is advantageous in health care research and Shaw et al. (2010) see pragmatism as useful in considering physiotherapy practice because it is outcome orientated and considers the importance of context as well as assessment in a variety of settings. In practising medicine and arguably for other health care professionals, Schifferdecker and Reed (2009) state that using mixed-methods is common everyday practice in that history taking is qualitative in

nature whilst physical examination and diagnostic testing lends itself to quantitative research and as such mixed-methods is familiar.

Having considered some literature about mixed methods research, I will move on to consider research design in relation to mixed method research.

4.3 Design: Priority Sequence Model

The design of a mixed methods study needs to be clearly set out. A convention has been set up over time with key authors being Morse (1991), Morgan (1998), Tashakkori and Teddlie (1998) and Creswell (2003). Morse (1991) introduced the concept of using capital letters to denote priority of method used. So if the priority method was qualitative this would be written as QUAL and the less dominant method, in the case to illustrate the point, quantitative, would be written quan. If this was followed by a plus sign the design was depicting a concurrent or simultaneous design for data collection. An arrow would represent a sequential approach in which one set of data (either qual or quan) would be collected first and then followed by the other.

In his 1998 work, Morgan suggests that a sequential approach is easier to implement and more likely to provide a productive combination and as such may produce greater impact. Hence in Morgan's work (1998) he displays four cells offering four design options, all of which are sequential in nature. Creswell (2003) discusses priority and sequence and so shows six designs; three sequential: sequential explanatory, sequential exploratory and sequential transformative. In addition the three concurrent designs are named: concurrent triangulation strategy, concurrent nested strategy and concurrent transformative strategy. Seeing these in visual form helped me to understand these concepts better. The visual representation adopted by Creswell (2003) is reproduced below, with a brief discussion of pros and cons of each design:

4.31 Sequential Strategies

Diagrams reproduced from Creswell (2003) in which the boxes represent quantitative and qualitative data collection.

4.311 Sequential Explanatory Design

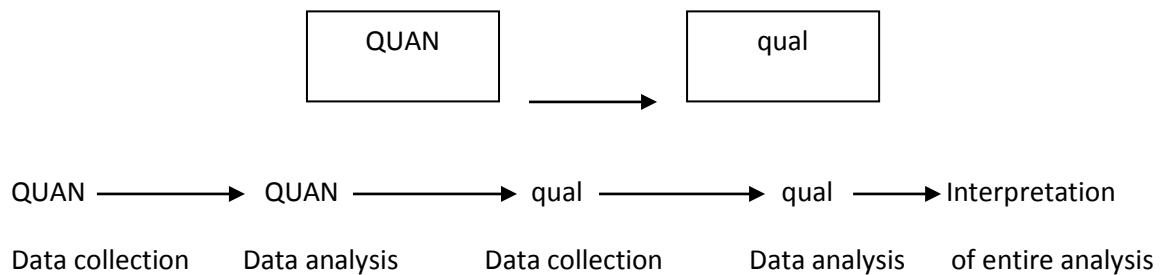


Figure 10: Sequential Explanatory Design

Creswell (2003) considers this to be the most straightforward of the designs, because it occurs in clear stages making it easy to write up and to report. Writing up of mixed methods research can be problematic, not least because of the volume of work created and as a consequence, Andrews and Halcomb (2006/2007) note that researchers must be creative in showing data. It is noted that this design can take a long time to execute particularly if both methods are given equal priority. Morse (1991) considers this a useful design which allows explanation to be considered for unusual results in the quantitative results by utilising a qualitative approach. Morgan (1998) concurs and gives an example of conducting in depth interviews in order to look for reasons why one clinic has higher patient satisfaction than another (pp368).

4.312 Sequential Exploratory Design

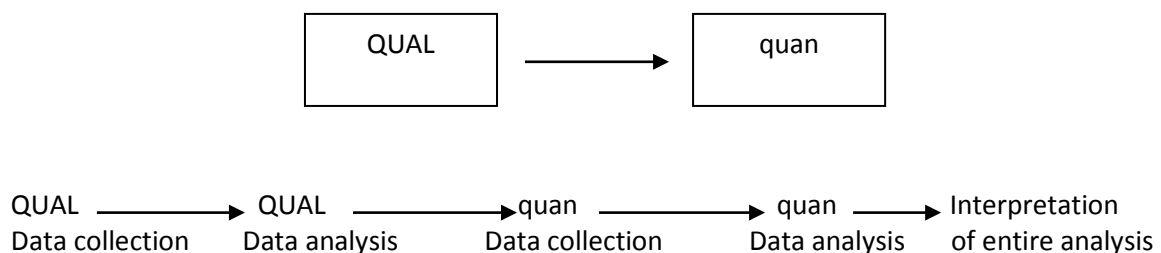


Figure 11: Sequential Exploratory Design

This design is similar to the sequential explanatory design, although here the priority is given to qualitative data, with findings integrated during the interpretation phase (Creswell 2003). Morgan (1998) explains that this design can generalise results to different samples and test elements of emerging theory. Creswell (2003) suggests that this can be useful in making a predominantly qualitative study more acceptable to those less familiar with a naturalistic approach. However, Morgan (1998) considers this

approach to be used least as it is problematic, not least because it may appear to suggest that, as Morse (1996) proposed, qualitative research findings are treated as tentative until quantitative results ‘confirm’ the findings. In some ways this sensitivity appears to relate to the heated debates of the paradigm wars.

4.313 Sequential Transformative Design

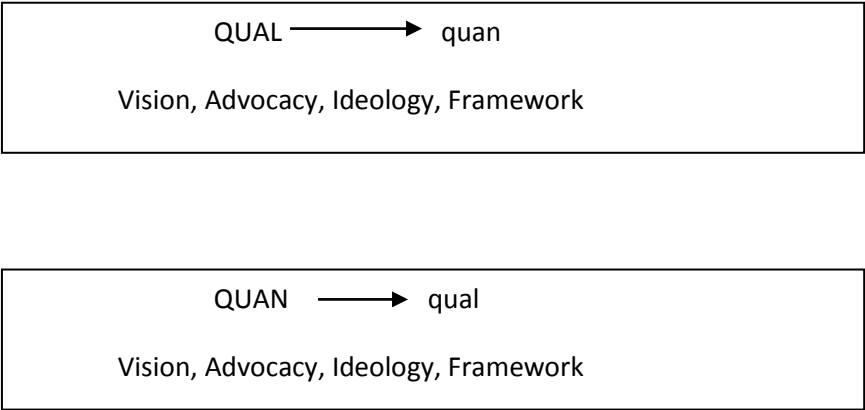


Figure 12: Sequential Transformative Design

Creswell (2003) notes that there is little written about this design to further guide and develop this approach. Its strength appears to lie in the importance of a theoretical perspective underpinning and guiding the design such that the conceptual theory is more important than the methods alone.

4.32 Concurrent Strategies

4.321 Concurrent Triangulation Design

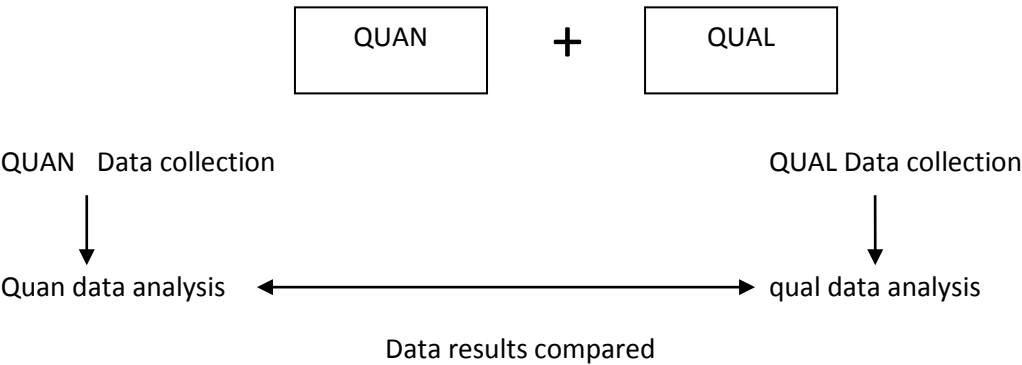


Figure 13: Concurrent Triangulation Design

Creswell (2003) considers this design to be most utilised and popular in mixed methods research partly because it seeks to confirm or corroborate findings within a single study, and by using both approaches seeks to minimise the weaknesses of one approach with

strengths of another. One limitation is that it requires considerable expertise in executing different methodologies. Morse (1996) offers a word of caution, stating that many researchers do not have the knowledge and ability to work seamlessly in two different methodologies. Despite reservations, Morse (1996) considers a solid triangulated project to be ‘essential, important and powerful’ (p4).

4.322 Concurrent nested design

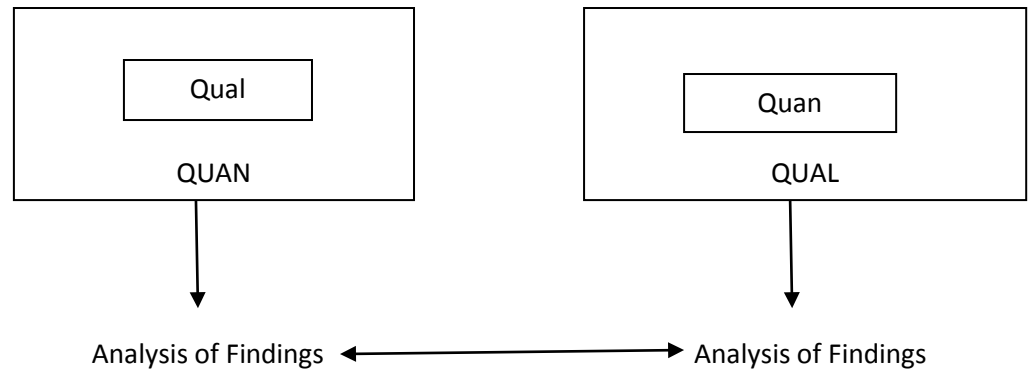


Figure 14: Concurrent Nested Design

This design is similar to the triangulation approach in that it uses one data collection stage during which both quantitative and qualitative data are collected at the same time. This design differs by having a priority approach, and nesting can mean that different research questions are examined by each approach. The collected data is mixed at the analysis stage (Creswell 2003). This design is described as having much strength, both in the collection of different data at the same time, as well as allowing different perspectives (Creswell 2003). Morse (1991) notes that for a predominantly qualitative design the ability to embed some quantitative data can enrich information provided by participants.

4.323 Concurrent transformative design

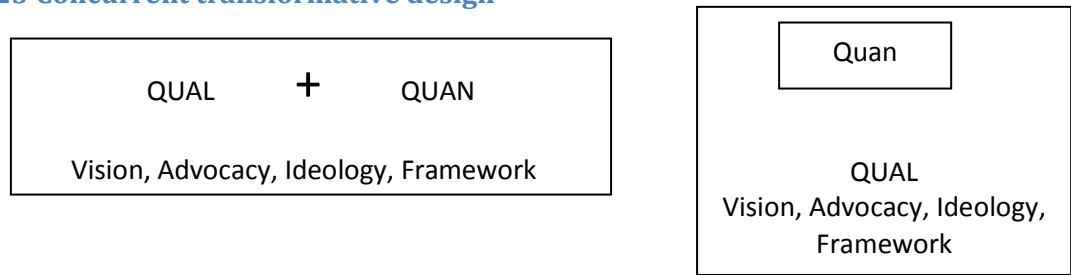


Figure 15: Concurrent Transformative Design

The differentiation of this design (and the sequential transformative model) from the previous two concurrent designs rests in the underlying conceptual framework which seeks to ensure that a theoretical base underpins the research (Creswell 2003). Creswell (2003) notes that a theory from social science may be used, for example, leadership theory or an advocacy/participatory lens such as gender or class may underpin the concurrent transformative strategy and the sequential transformative model, setting it aside from the other designs.

This section has considered research design particularly in relation to priority and sequencing of the design, but there remains a major criticism of mixed methods research and pragmatism. This is that in taking a 'pick and mix' approach to the research methods employed (Gilbert 2006 p. 206), it fails to address the important theoretical underpinnings of the chosen research methodology. Despite Morgan's (2007 p. 60) contention that issues of ontology and epistemology are 'purely metaphysical' and should not direct the research process, I wish to show due consideration to theoretical aspects and so, in the next section, I will consider my stance in relation to ontology, epistemology and axiology.

4.4 Reflexivity and my stance within the project

As part of the theoretical underpinning of my study, I have chosen to write in the first person. My decision is influenced by the ownership I feel of this work, when use of the third person is considered to imply shirking of responsibility (Mohr 1999). For Hyland (2002), use of the first person is a central aspect of pragmatic competence. Webb (1992) began a debate in nursing literature about the pros and cons of first and third person usage in academic work, claiming that use of the first person can be in keeping with research epistemology as well as increasing reflexivity of the researcher. In this way, I hope to demonstrate how my research is credible (Lincoln and Guba 1989), because I see myself as an integral part of the study. I shall employ this stance not only in relation to the qualitative aspects of mixed methods but perhaps more controversially to the quantitative aspects. As noted above, positivism prides itself on the objectivity and rigour and ability of the study to be replicated, assisted by the invisibility of the researcher within the process. Webb (1992) argues that all research is highly social and influenced by researchers, using examples such as decisions made on data collection

methods. The reader of my study will note in the methods chapter in section 5.41 that decisions are listed associated with the filters applied to PARR data. As these were active researcher decisions, I feel justified in continuing to use the first person.

Until this point in my academic career, I have considered myself as an interpretivist, preferring my views of ontology (the nature of reality) to be based around the premise that there are multiple realities and as such subjectivity is important, because realities are constructed by people (Lincoln and Guba 1989). I have been reflecting on how I came to that stance and I think it was bound up in my pre-registration training at The Middlesex Hospital in London. In the early 80s research in nursing was beginning to have an influence. Such work as Stockwell's Unpopular Patient (1972) sticks in my mind, but more so than that was the work by McCaffery (1968) on pain and in particular the phrase 'pain is what the patient says it is'. While it should be noted that this work has been critiqued as failing to acknowledge people who are non-verbal (Herr et al. 2006), for me, McCaffery's work set out the importance of subjectivity and attempting to gain insight into what was happening to patients by listening to them.

It was not until I undertook my Masters that I began to take a fractionally more favourable view on post-positivism, through reading more and considering ideas as discussed earlier around continuums of research (Strickland 1993), rather than separate sides (Hammersley 1992). As such I feel increasingly comfortable in considering reality (ontology) as able to consider different viewpoints (Teddlie and Tashakkori 2009). Teddlie and Tashakkori (2009) state that an important aspect of the ontology underpinning pragmatism is knowing where the researcher sits within the process and it is that which I am attempting to explain to the reader at this point. Indeed Johnson and Onwuegbuzie (2004) consider that within considerations of ontology, there is space for:

'mental and social reality as well as the more micro and more clearly material reality' (pp 15).

In considering my epistemological stance in the light of the work I am presenting, I would previously have placed myself as part of the research, in collecting qualitative data. Undertaking a mixed methods study, means that part of my relationship remains subjective (Lincoln and Guba 1989) and yet in considering rows of data generated from

the PARR tool (Kings Fund 2004)(to be explained in section 5.3), this has called for a level of objectivity through which I have a lesser influence than if I were conducting an interview. As such, Teddlie and Tashakkori (2009) consider the epistemology of pragmatism underpinning mixed methods contains both objective and subjective aspects. Johnstone (2004), when considering her epistemological stance declared 'insider' characteristics of the research which arose from her professional background. In following suit, my professional background in community nursing and latterly my work around long-term conditions and workforce transformation is openly stated to ensure transparency within the work. Clarke (2009) suggests that it is entirely feasible that an author's own ontological and epistemological perspectives can include aspects which are measured and generalisable, whilst also showing that some things can be unique to individual participants.

Axiology refers to the role of values in inquiry and from the pragmatist viewpoint, Teddlie and Tashakkori (2009) state that values play a large role in interpreting results. Johnson and Onwuegbuzie (2004) suggest that pragmatism takes an explicitly value-oriented approach to research and as such often represents those in society who may be under represented or discriminated against. Reading this made me consider my own study. Although the central focus is on the role of the Community Matron, it also considers how this role impacts on individuals with long-term conditions. Thinking sociologically, Parson's (1951) development of the sick role clearly stated that individuals who are ill must, as part of their social role, want to get better as soon as possible. In order to do so, they should seek technically competent help and co-operate. As such those individuals with long-term conditions, which by their nature are permanent, are disadvantaged, and therefore the axiology associated with pragmatism would appear to be a good 'fit'. However, the idea of disadvantage is somewhat negated by a theory put forward by a fellow sociologist, Gordon (1966) who introduced the idea of 'the impaired role' whereby the individual does not give up normal role responsibilities but is expected to maintain normal behaviour within the limits of the condition. Modification of life situations may be necessitated by the impairment. In addition, the individual does not have to want to get well but rather make the most of remaining capabilities and must realise potential whilst accepting limitations associated with the impairment. Although

clearly stating the role in society, even applying Gordon's theory still shows that disadvantage can be a factor as modification of life may result in reduced job prospects and earning power as just one example, thus linking individuals with long-term conditions as having the potential to fall within the cycle of disadvantage (Rutter and Madge 1976).

As Sheppard (2002) and Tashakkori and Teddlie (2003) state, mixed methods is not inherently good practice, so a clear rationale must be provided. Equally Johnson and Onwuegbuzie (2004) note that it is important to explicate an underlying philosophical basis and that is what I have attempted to do.

Having set out my personal stance in respect of ontology, epistemology and axiology, I now wish to provide additional reasons why I consider a mixed methods design, underpinned by a pragmatic approach, to be the best way forward. One reason is the complex nature of the area under investigation. Sheppard et al. (2002) states that studies set in the community are often plagued by methodological and conceptual difficulties. Andrews and Halcomb (2006-7) consider that community health research needs to be flexible, inclusive, creative, but also practical enough to take account of the complexity of issues being studied. It may not seem obvious at first glance how the research question at the heart of this work is complex. However, briefly, the role of community matron was set up in response to the growing numbers of individuals with LTCs (DH 2004). One aim was that they should work with those at most risk of hospitalisation in order to reduce or prevent individuals going into hospital. Just one complexity is the number of reasons why individuals are hospitalised, not least disease trajectories (Lynn and Adamson 2003) which mean that their health is at high risk of deterioration regardless of intervention. Interventions for this group are numerous: medication, input of health and social care not just community matrons, so the context is complex. As such a mixed methods design allows a complex research problem to be explored from many angles (McAuley et al. 2006).

By undertaking a mixed methods design, I want to appeal to a wide audience. Although my heart is an interpretivist, I can see the value of combining methods. In the current economic climate, commissioners are searching for evidence to justify approaches and

yet politically papers such as the Darzi report (DH 2008a) and Equity and Excellence (DH 2010a) still value patients at the heart of the NHS, receiving care of good quality and that listening to users of the services is good practice. As such, for me, using a mixed-methods design seeks to provide information which can be widely understood, and utilised. By combining methods, it will seek to address issues of quality of service within the reality of economic austerity.

Having considered the theoretical underpinnings of this project, I offer a rationale for the choice of model used.

4.5 Chosen Research Design

For this project, I reduced the choice of design to two before making a final decision. The final two were a sequential exploratory design and a concurrent triangulation strategy. The latter, concurrent triangulation strategy was chosen, but with minor modifications as depicted below. It could be argued that sequential exploratory design with its emphasis on advocacy would be a 'good fit'; however it was the notion of triangulation which made the decision. One change was to give priority to the qualitative aspect. As discussed earlier, I enjoy this aspect of research more, but in order to explore the research question and to examine a different aspect of the role of community matron than that already available in the literature, and so in an attempt to 'discover new knowledge' in pursuit of a PhD, the consideration of quantitative data was seen as important. The second modification made by me for my PhD was the collection of a second wave of qualitative data and as such this may present a model which could be titled most simply as a triangulation strategy. A representation is given to the reader next:

4.51 My model of triangulation in a mixed method design

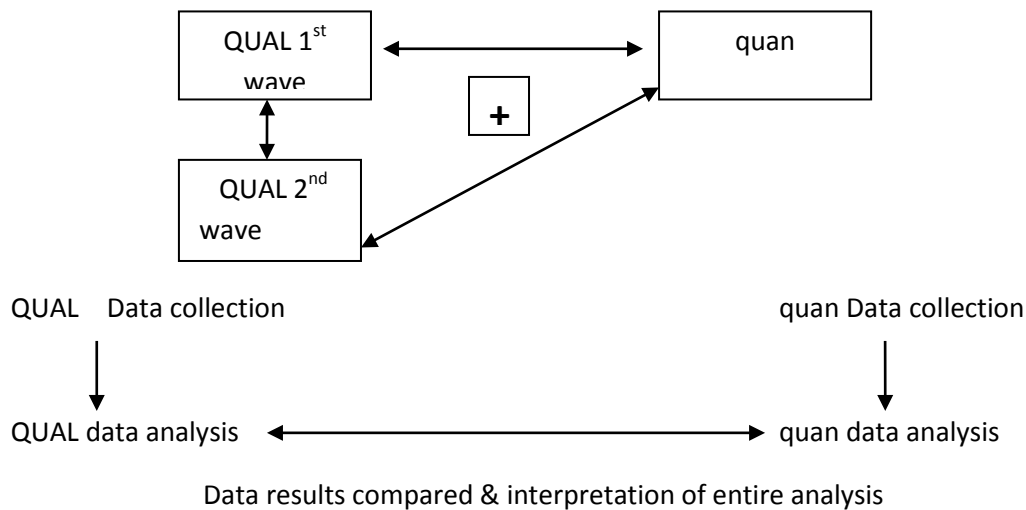


Figure 16: My Model of Triangulation in a Mixed Method Design

4.6 Chapter Summary

In summary, I have viewed research theory through a historical development and in terms of research being on a continuum within this chapter. As such it has explored aspects of positivist thought, followed by post-positivist assumptions, then the rise of interpretivism and constructivism. At this point in research development there was much debate around paradigms which have been referred to as the paradigm wars culminating in mixed methods research underpinned by the philosophy of pragmatism. I have explored the work of key scholars in relation to the establishment of mixed methods as a 'third paradigm' and the research designs which developed from the mixed methods school. Finally, I have reflected on my own stance within the research and design for the proposed study. In the next chapter, I will explore methods and the rationale for choices made.

Chapter 5: Methods

5.1 Introduction

The last chapter explored theoretical underpinnings of the chosen methodology and provided a rationale for this choice. In addition the chosen research design was presented. In this chapter I present the methods used to collect data and the rationale behind these choices, some of which followed on from the parent project which my study utilised and has expanded. Therefore, the parent project is outlined (section 5.2). Sampling and data collection is described and issues relating to access and consent are presented. The means of analysing both quantitative and qualitative parts of the study are provided and limitations of the study are offered and discussed.

5.2 Parent Project

The then new role of the community matron was introduced as a consequence of the NHS Improvement Plan (DH 2004a). However it should be noted that the title 'community matron' has only been adopted in England and not by the devolved governments in Wales, Scotland and Northern Ireland. The role comprises the use of highly skilled clinical nurse specialists operating a system of case management. Although broad parameters for the role have been established, different models are to be found in practice. In area 1, the model followed was that of community matrons who worked as autonomous practitioners. Their working hours were Monday to Friday, 9am to 5pm. This was in line with the way the role was envisaged at inception and focussed around the domains of case management.

A team from the Applied Research Group in Public Health from within the Faculty of Health and Life Sciences at Coventry University was commissioned to undertake a review of the operation of the Community Matron Service in a West Midlands inner city area (known as area 1 in the doctoral study). The review, which I led (exact details of my role in the parent project can be found in Appendix 3), had the following aim and objectives.

Its aim was:

To assess and evaluate the extent to which the Community Matron Service in a West Midlands inner city area has implemented case management approaches to care and the impact this has had on reduction in unnecessary hospital admissions, particularly amongst minority ethnic groups.

Its objectives were to:

- Investigate the operation of the Community Matron Service in the specified area
- Identify the extent to which Community Matrons have succeeded in implementing the nine elements of case management
- Assess the impact of the Community Matron role on patient journeys, particularly in respect of hospital admissions and re admissions
- The extent to which the role and case management have impacted on the qualitative experience of patients and carers.

The executive summary of the study findings are presented in Appendix 2. As part of this project, I was responsible for gaining ethical approval for the mixed method approach which was used, and for collection and analysis of the qualitative aspects of the study and exploration of twelve patient journeys which linked the qualitative findings to data held in the PARR system. PARR is an acronym for 'patients at risk of re-admission to hospital' and is a predictive tool developed by Health Dialogue and the Kings Fund, which uses data based on past hospital admission to predict future hospital admission (Kings Fund 2004). The rationale behind this was to explore whether reductions in hospitalisation which were reported by patients, carers and community matrons were confirmed by examining another data form. The idea was one of 'backing up' claims rather than generalising them. Implications for using a mixed methods approach have been examined in the methodology chapter. In addition, a matched group of anonymised patients who were case managed by community matrons was explored with a matched group who were not case managed by community matrons (or case managed by any other health or social care professional).

In presenting the finished report, it was evident that what appeared to matter most to the project commissioners was that community matrons, using case management for vulnerable and often elderly patients with several co-morbid long-term conditions, had

not been successful in a statistically significant way in reducing admissions and re-admissions to hospital. This would seem to be in line with new managerialism which placed emphasis on economy, efficiency and effectiveness (Alcock et al. 2008). By the mid-1990s the New Public Management paradigm had become influential. The following changes noted by Clarke and Newman (1997) put emphasis on outputs being measured by quantitative performance indicators, as seemed to be the case in the parent project. In addition, new public management also put an emphasis on quality, but the quality of service noted by patients and carers in the above study, as well as the quality of service delivered and described by community matrons appeared of lesser value and appeared to conflict with New Labour's ideas of patient choice, promoting user involvement and empowerment (Alcock et al. 2008). In 2001, Newman identified five objectives in the governance of social welfare, in which health can be seen to sit. Two of these: 'synergetic solutions' (whereby new and innovative approaches to service provision are organised by bringing together other expert partners) and 'joined up solutions' (which ensure integrated and coordinated approaches) were evident in the data collected for the parent project. However, to the project funders their value appeared secondary in importance, particularly when considered next to the importance of the metric of reducing hospital admission. The rationale for this decision lay with what the funders felt would 'sway' commissioners.

In the production of my thesis, various methods of data collection were used to meet the mixed methods design. The exact process of data collection is shown in figure 17 below. Qualitative data collection comprised the use of semi-structured interviews and audio diaries. One to one semi structured interviews were undertaken with community matrons, their patients and family carers in area 1, which as noted in section 3.3 formed the basis of the original funded project. However the qualitative aspects of the original study showed examples of nursing practice which were difficult to record and yet showed nursing practice that is in line with policy directives. I decided, in consultation with my supervisory team, to collect further qualitative data from an additional two areas thus allowing comparison in relation to different models of delivery by community matrons. The methods of data collection remain in line with those described above: semi-structured interviews and audio diaries. The views of patients and family carers

were also sought in the two additional areas using semi structured interviews. Additional strands of data collection have been added by exploring the views of GPs who will form part of new commissioning groups around the factors which may influence their commissioning of such services as community matrons. The decision to undertake semi-structured interviews with GPs in areas 2 and 3 followed the failure to engage GPs in area 1 by the use of a short questionnaire. The questionnaire used in the parent project comprised three questions which were similar to those utilised by Leighton et al. (2008). The questions asked GPs to describe their view of the community matron service in area 1, state aspects of the service which worked well and ways to improve the service. In area 1 only six replies from 150 were received and follow up via practice managers to remind the GPs was no more successful. As the depth of data gained was very limited, a decision was made through the supervision process, to undertake semi-structured interviews with GPs in areas 2 and 3 instead. Exploring their understanding of the role of community matron was part of my rationale in asking from former commissioners and GPs who form part of new CCGs to participate. Managers in provider services have been interviewed to explore what factors influenced service delivery models in relation to the role of community matron and the care of patients with co-morbid LTCs. A pragmatic decision, under guidance of my supervisory team was taken to limit data collection to the chosen groups as stated in figure 17. Essentially, those chosen to participate were people who had potential to affect the role (managers, GPs, former commissioners) rather than peer professionals such as DNs whose influence over the role would be less.

The quantitative arm (from original area 1) explored patient journeys using data from the PARR (patients at risk of readmission tool, Kings Fund 2004) database. Additional use of the database allowed a much larger anonymised sample of community matron case-managed patients, enabling scrutiny in relation to in-patient bed days before and after patients' admission onto the community matron caseload. To allow for shifts in the underlying aetiology of patients case-managed by community matrons, these rates were compared with a matched comparison group of patients not case-managed by a community matron.

It is important to differentiate between the broad methodological approach taken to this research which was described in the previous chapter and its methods which Polit and Beck (2004) describe as:

‘The steps, procedures and strategies for gathering and analysing data in a research investigation’ (pp 723)

In order to consider the methods in more detail I will begin by exploring evidence for qualitative methods and the use of interviews, and audio diaries. I will conclude the chapter by examining the methods used for the quantitative aspect of the study.



*Run 2 of PARR data: caseload active and archived Jan 10

**Run 6 of PARR data: Risk Data Anon (hospital attendances and admissions)

Figure 17: Process of data collection

5.3 Qualitative data collection

5.31 Interviews

Research interviews are one of the commonest ways to collect qualitative data (Casey 2006, Parahoo 2006, Polit and Beck 2004). Polit and Beck (2004) define interviews very simply as:

‘A method of data collection in which one person (the interviewer) asks questions of another person (a respondent); interviews are conducted either face to face or by telephone.’ (2006: 721)

Parahoo (2006) goes further and considers that qualitative interviews are a data collection tool which can be used to explore attitudes, beliefs and experiences of health and illness by those experiencing the situation. Experience of a situation can be examined from any number of viewpoints, so patients and health care professionals. The data gathered can be used to inform decision making and /or to build up a body of knowledge (Parahoo 2006). Advantages and disadvantages are reported in the use of interviews and these are explored in the following section, which demonstrates rationale for the decisions I took.

5.311 Advantages and disadvantages of interview as a method of data collection

Within the context of my study, it was important for me to engage with participants, both lay and professional to hear their experiences in relation to community matrons and case management, and to explore the issues which were important to them, thus providing a ‘rich vein of data’ commonly associated with qualitative data (Parahoo 2006, Polit and Beck 2004).

A brief overview of advantages and disadvantages was considered in relation to the decisions made about using interview. Advantages of interviews are noted as allowing flexibility when exploring a topic and the ability to clarify what participants say which is not possible from data collected by questionnaire (Burns and Grove 2001, Holloway and Wheeler 2002, Tod 2006). Although some authors (Burns and Grove 2001) note that response rates can be high using this method, it could be considered highly dependent on the means of approaching individuals about participation and the nature of the topic to be investigated. Conversely, disadvantages are noted as the time consuming nature of interviewing, which can, in turn, lead to smaller sample sizes, because of practical

implications for the researcher (Burns and Grove 2001, Holloway and Wheeler 2002). Both interviewer effect and social desirability (when participants may give ideas which they think are those that the interviewer wishes to hear) are known disadvantages (Polit and Beck 2004). At least being mindful of these issues allows the researcher to prepare for undertaking interviews (Byrne 2001).

5.312 Types of Interviews

Within my work, a semi-structured interview was chosen. This decision was made on the basis of reading and also familiarity, in that I considered that most people have a broad understanding of a semi-structured interview whilst not being aware of the intricacies debated by Parahoo. This appeared to offer a sound balance between allowing participants freedom to express their thoughts whilst the researcher remained able to maintain some control in keeping the interview focussed to the research question as noted by Morse and Field (1996). Additionally, I considered that the use of a fully structured interview would detract from being able to probe and explore the topic in more detail, should aspects arise in relation to the research question which had not been previously considered (Polit and Beck 2004). Also that the varied backgrounds of participants in terms of education, illness journey (for patients) and professional journey for community matrons, GPs, former commissioners and managers precluded the use of a uniform approach. This decision making process is built upon literature.

Three types of interview are commonly cited and these are structured, semi-structured and unstructured interviews (Parahoo 2006). Other authors have chosen to re-name the interviews, for example Babbie (2007) names interviews as standardised; semi-standardised and unstandardised, however the general meaning would still appear to be clear and choice of terminology becomes a personal one rather than one based on deep methodological debate. Parahoo (2006) argues that researchers can misname the type of interview they are conducting. Parahoo (2006) contends that many researchers claim to use a semi-structured interview when in fact they are using a focussed qualitative interview which has broad questions aimed at promoting interaction rather than constraining and maintaining a degree of structure. Parahoo (2006) argues further that the term unstructured is misleading, because the question should be asked if an interview is truly unstructured what is the rationale for its conduct, and how does it

differ from conversation? In other words there are no set questions and the direction of the interview is entirely guided by the participant (Moyle 2002). For Ryan et al. (2009), unstructured interviews are best used in areas where very little knowledge is available. Walker (2011) suggests that interviews sit on a continuum, with each type of interview affected by the amount of control exerted by the researcher, and the phenomenologist van Manen (1997) concludes that the decision on which type of interview to use should rest solely in consideration of the research question which prompted the need for interview to be undertaken. The degree of structure of the interview is also likely to be considered in relation to proposed analysis and the proposed objectives.

The decision to undertake face to face interviews rather than telephone interviews was to some extent a personal one, because I have an irrational dislike of telephones. However, consideration was given to building up a rapport with participants which I considered best achieved face to face, with non-verbal communication lost in a telephone interview. Additionally, in relation to the patients who offered to be interviewed, many were very unwell and as such being present allowed me the ability to judge and discuss stopping the interview if the patient appeared tired or unwell. Perhaps linked to this is Kvale's (1996) argument that silence is an important part of undertaking an interview. For Kvale this may be interpreted as silence in respect of the participant taking some thinking time, whereas in the case of this research silence was often necessary for those participants who were patients, to recover physically from the exertion of speaking. I consider that this would have been more difficult to manage on the telephone.

In order to explore some of the issues mentioned above in more detail I will consider these issues under the broad heading of ethical considerations.

5.32 Ethical Considerations of using interviews

5.321 Role of the interviewer

The role of the interviewer is important, because the interviewer can influence what data is gathered as a result of past experiences (Parahoo 2006). The ability to put participants at ease, and yet to remain passive through the interview and not lead the participant, is noted as a skill required by interviewers (Casey 2006). Preparation for

interviews is important and the sequence in which questions are asked can be seen as a part of this process (Polit and Hungler 1995). For me, practical experience of undertaking an interview as part of my Masters study and subsequent research projects, as well as examining underlying literature, ensured preparedness. Easy, non-threatening questions, such as demographic questions should precede questions which are considered essential and any sensitive questions should not be broached until after a rapport has been established (Ryan et al. 2009). As such the researcher should ensure that participants are clear about their role in the process before they agree and that they are free to withdraw at any point during the process without harm to themselves. Prior to interview for my study, once preliminary agreement had been given, information sheets were sent out in advance of the interview to allow participants opportunity to consider their role. Their understanding was checked as part of the process of obtaining informed consent along with a reminder of their being able to withdraw at any point without risk of harm (Ryan et al. 2009). Corbin and Morse (2003) suggest that the role of the interviewer should be skilled enough not to provoke distress, but should distress occur, that the researcher has suitable skills to diffuse the situation. Indeed, Johnson (2004) challenges ethics of protecting participants from getting upset, noting that many people consider that 'having a good cry' can be beneficial and this happening in a health research environment could lead to signposting for help. As alluded to above, the fact that in this research I am a nurse was deemed by the ethics committee who approved the study to be beneficial in recognising physical distress. It is noted in the literature that there can be conflict between a therapeutic relationship and a research relationship and this will be explored next in relation to interviews.

5.322 Therapeutic versus research interviews

Tension is presented as the need to distinguish between therapeutic and research interviews. For me, who is a nurse by background, this required reflection and as part of the study rigour this area was examined. In two interviews, patients did ask me questions directly related to their treatment and experience of healthcare. I did find this scenario difficult in the sense that even though I am now a nurse educator and researcher, at heart I remain a nurse. My natural instinct then, is to work with the person to explore possible solutions. I had to draw hard on my resources to remember

that this was not my position and to refer the individuals concerned back to their own community matron. It should be noted, that in my professional opinion, the issues I was asked about were not matters of life and death, else my response would have certainly been more active. I have explored the literature in relation to this area.

When considering the elements required in a therapeutic interview, it is not difficult to see how a tension may arise between therapeutics and research (Bulpitt and Martin 2010). It was important to be mindful of this tension when preparing for interviews with patients and their family carers. For Rogers (1951) a therapeutic interview comprises:

- Reflecting
- Asking questions that are open
- Being non directive
- Using options eg. either/or
- Allowing time to answer

These aspects can all be considered as good practice in research and Ritchie and Lewis (2003) note that skills of a qualitative interviewer should include:

- A mind which is clear and logical
- The ability to listen
- The ability to remember
- A desire to be curious
- The ability to establish a rapport and show empathy

Despite similarities, for Kvale (1996) there is a clear distinction between the two and whilst both therapeutic and research interviews may lead to increased knowledge and possible change, the emphasis on change in a therapeutic interview is at an individual level and the change in a research interview is in intellectual understanding. Bulpitt and Martin (2010) take this further and state that the difference may be more apparent: a therapeutic interview seeks to ease psychological distress whilst a research interview has its principal aim as increasing intellectual understanding. The increase in understanding may in turn, benefit the researcher primarily, but may lead to benefits for the participant and wider academic and professional groups. As such, in choosing to

conduct semi-structured interviews with participants who are patients, I needed to be clear about my role in the process and to direct any therapeutic questions to an appropriate other professional, in order to reduce 'role conflict' (Asselin 2003: 103), as discussed above. Authors have noted though, that in collecting data which allows participants to talk about experiences, many participants found the experience positive even if they became upset (Johnson 2004; Drury et al. 2007).

5.323 Power

Additionally, when considering the use of semi-structured interviews with the community matrons, knowledge that I am a nurse can be advantageous, but also problematic, in relation to knowledge as a fellow nurse (McConnell-Henry et al. 2009). Many interviews undertaken involved nurses and as such this could be seen as an advantage in negating power issues, where the researcher is generally seen as having 'the upper hand' (Oakley 1981). In undertaking interviews with patients, and their family carers issues of power are evident and reducing this imbalance is a key characteristic of successful interviewing (Fontana and Frey 2000). Nugus et al. (2010) make a distinction between 'competitive power' and 'collaborative power', which I consider a useful distinction in research. The latter implies a partnership approach whereby working collaboratively produces a power which ultimately may guide practice improving issues for staff and patients alike. Kvale (1996) considers that no matter how conversational the interview may be, the relationship between the interviewer and interviewee is not equal. Having this knowledge prior to interviewing allowed me to start in a gentle manner with questions on more general topics (Ryan et al. 2009). Additionally I considered how best to establish a rapport (Walker 2011), and felt this was instrumental in overcoming the difference. The power of being a nurse is seen as offering skills to the researcher which empower rather than hinder (Leslie and McAllister 2002). Such skills gained from nursing can be easily transferred to ensure proficient research interviews are conducted (Colborne and Sque 2004). In contrast, as a nurse researcher, I felt very nervous when I went to interview GPs.

A further means of reducing power imbalance when conducting interviews, is self-disclosure (McConnell-Henry 2009). Offering information about self can reduce power imbalance by putting participants at their ease (Stanley and Wise 1991). Self-disclosure

can impact the power imbalance and with nurse participants being aware of my own background this could be seen to negate some of the acknowledged power imbalance (Butler et.al. 2007). Conversely, Jackson et al. (2008) warn that self-disclosure may have the effect of influencing the participant, by leading and contaminating conclusions. However, Russell (2002) and Wilson (2009) conclude that there is an inevitability that researchers form a relationship with participants and that this is a natural part of the process. For Dickson-Swift et al. (2006) this means boundaries are blurred between the role of the researcher and participants who may see the researcher in the role of counsellor or even as a friend. Either way, self disclosure should be considered from an ethical standpoint (Davies and Dodd 2002). Davies and Dodd (2002) consider that if a participant seeks clarification or directly asks a question of the interviewer it may be ethically wrong to ignore this. Within the research, I found myself actively building a rapport with participants, rather than creating distance, and as such exuding understanding and empathy. Such behaviour needs to be examined in the light of reflexivity.

5.324 Reflexivity

Carolan (2003) notes that definitions of reflexivity differ, but despite this there is consensus that the researcher should be transparent in terms of their background, experiences and influence within the study (Carolan 2003, Hand 2003, Parahoo 2006). Reflexivity is therefore important throughout the research process and should be seen in decisions made in relation to study design, methodologies, methods, data collection and presentation of findings.

Reflexivity can be seen as a means of establishing trustworthiness within qualitative research (Polit and Beck 2004). Finlay (2002) contends that reflexivity and reflection are often used as interchangeable terms. In fact they may best be considered on a continuum, with reflexivity being an active part of the here and now of research whilst reflection usually occurs at a distance from the event (Finlay 2002). Schon (1983), however, would argue that reflection can occur either after an incident or indeed during. For Gilgun (2005) reflexivity is important because it enhances sensitivity to the concerns of participants and as such is a matter of quality and ethics. As such, researchers are reflexive when they are aware of the multiple influences it is possible for them to have

on the research process. This is inevitable but the way the researcher deals with it is key (Finlay 2002). Transparency in relation to the background of the researcher allows overt scrutiny by participants and readers (Coneeley 2002).

The process of reflexivity has its critics. One such critic is Seale (1999) who considers that psychoanalysis is the only likely means of reaching the level of self consciousness required by reflexivity. However, Denzin and Lincoln (1998) defend the use of reflexivity as a means of enhancing credibility in qualitative research.

As part of my reflexivity I was honest about my background and willing to openly discuss the context of the study. Additionally I kept a reflective diary after each interaction, as a reminder of context and of the decision making processes I undertook. Further consideration of my stance is given in section 4.4.

Choosing interviews as a method for this study has been explored in relation to advantages and disadvantages, types of interviews, and in relation to the ethical considerations concerning role of the interviewer, therapeutic versus research interviews, and power.

5.33 Audio Diaries

An additional method of data collection was chosen for the community matrons; the use of audio diaries. Critics of qualitative research and indeed any self report argue that it is anecdotal, unscientific, and lacks generalisability due to small sample sizes and a sample which may exhibit bias as noted above (Parahoo 2006). Further debate on this can be found in the methodology chapter, (section 4.23), but perhaps considering the transferability of qualitative research in relation to description of context (Geertz 1975) may be more useful. As a means of attempting to overcome participants telling the researcher what they think the researcher wishes to hear (Berg 2009), a choice was made to use audio diaries. Initially the idea of observation was mooted, but in addition to one to one interviews this was felt to be too labour intensive, as noted by Casey (2006). Although an advantage of observation is seen as gaining firsthand knowledge which could be cross referenced against interviews (Casey 2006). Factors such as the Hawthorne effect may occur as participants try to act in a manner conducive to being observed and which Alder and Alder (1987) state is hard to avoid. Mulhall (2003)

suggests this is unlikely to happen in a busy environment where maintaining behaviour which is different to that normally exhibited would present a challenge. This difference of findings could be seen in relation to environment where the observation is planned. Mulhaal (2003) may be referring to a ward environment where the busy environment may be more likely to diffuse the effect of a researcher observing, whilst Alder and Alder's (1987) points can perhaps be considered pertinent to a community/ home environment where work is conducted on a one to one basis.

Having dismissed observation as a method, the idea of diaries was suggested by a member of the original research team. Clayton and Thorne (2000) note that there is little literature available on the use of diaries as a data collection tool. With my knowledge from a nursing background, I was concerned about asking other nurses to maintain a written diary because of concerns about the amount of time required to write it and so the notion of audio taping their thoughts materialised. Jacelon and Imperio (2005) report the use of this method of data collection, but for patients and not nurses. In their study findings they report audio diaries as a rich data source and suggest a period of 2 weeks maximum for the diaries to be used (Jacelon and Imperio 2005). This time period was used in the study and generally the idea of audio diaries was met positively and provided data which the community matrons clearly felt strongly about and wanted heard as part of the research.

In area 1 re-consent was gained to use data from 11 out of 15 audio diaries. In areas two and three community matrons were purposefully asked if they would keep an audio diary. All who were approached consented (area 2 n=2; area 3 n=3). The digital voice recorders used were Olympus DS-30 models which had been purchased as part of the funded evaluation. The devices are small and easily carried in a pocket. An instruction sheet was given out with the recorders (see appendix 5). A practical demonstration was also given of the basics, comprising on, off and record with the advice to record 'elements of your role which you consider do not get captured elsewhere'. Considerable freedom was allowed in how and what was recorded. Some matrons systematically recorded daily; others after individual visits. One diary contained just 20 minutes of material; another contained three hours representing 20 entries.

5.4 Quantitative Methods

As noted in the methodology chapter, the quantitative aspect of this study is small and in some respects can be considered background to the qualitative aspects. Exploring the impact of the community matron role in area 1 on hospital admissions showed limited impact of the role in relation to that outcome. As reduction in hospital admissions was a major policy driver, the metric of reducing hospital admissions was an important focus for the commissioners of the original study. However this metric did not show the numerous other areas of nursing practice undertaken by community matrons and hence the dominant approach of qualitative data collection in this work. The quantitative methods were formulated as follows.

Quantitative methods for this study involved scrutiny of the Patients at Risk of Readmission (PARR) data generated by area 1 using the PARR tool (Kings Fund 2004). In 2005, Essex Strategic Health Authority (SHA) commissioned the Kings Fund to develop a case finding algorithm, which would identify individuals at high risk of re-admission to hospital. This request was on behalf of all the SHAs in England, the Department of Health (DH) and the NHS Modernisation Agency. In order to fulfil the commission the Kings Fund worked with Health Dialog and New York University. Previous models of prediction have been used and include threshold modelling which identifies patients who meet a specific criterion eg, hospital admission (Webb 2006). Examples of this type of model are Castlefields (Lyon et al. 2006) and Evercare (Kane et al. 2003, Gravelle et al. 2007). However it should be noted that there are clear distinctions between the two models. The Castlefields model, which integrated health and social care within an UK setting, was more successful in reducing hospital admission in a high risk group (Lyon et al. 2006). This contrasted with Evercare which was a model set up in the USA system with health alone and did not transfer as successfully to the UK in respect of admission reduction (Gravelle 2007).

Another model is that of clinical knowledge whereby clinicians use clinical knowledge, instinct and training to highlight high risk patients. Dudley et al. (1996) concluded that although clinicians could highlight current high risk they were poor at predicting future high risk. The predictive model, such as PARR, seeks to link different variables to predict outcomes. Curry et al. (2005) found this type of model more effective in predicting

future service use. In the course of the Kings Fund Project, two risk stratification tools were developed:

1. The PARR tool: software which used hospital in patient data to highlight those at risk of re-admission within a year. This was modified to become PARR++ in 2007
2. Combined Predictive Model (PARR combined): this used expanded data which comprised inpatient, outpatient, Accident and Emergency and General Practice (GP) data

In order to develop the software, Billings et al. (2006) examined five years of data from hospital episode statistics (HES) and further developed and validated the tool by using two 10% samples from the whole data set. Nnoaham (2006) identifies a potential flaw, because there is no safeguard against the samples overlapping. However, Nnoaham does concede that by using samples as small as 10% this does go some way to minimising the risk.

Characteristics of PARR include:

- The use of some conditions known to prevent future admission if effectively managed
- Use of trigger events: hospital admission
- Use of a broad range of variables
 - Data on previous hospital use
 - Characteristics such as age, sex, ethnicity
- Designed to be used in real time or as an archive (Billings et al. 2006)

Limitations noted by Billings et al. (2006) are that effectiveness of the PARR tool is reliant on the hospital episode statistics (HES) data and if there are gaps in the latter this will affect predictability. In addition, the PARR tool is not strong on predicting emerging risk, as it relies on prior admission.

Following publication of Billings et al.'s (2006) paper there were several responses published in the British Medical Journal (BMJ). Most comments were positive (Parker 2006, Gonzales-Morales et al. 2006), recognising the need and worth of an instrument

such as PARR in the battle to manage individuals with long-term conditions effectively. For Gonzales-Morales et al. (2006), working in Cuba and so with a broadly similar health system to the UK, in that there is free medical and hospital care for the whole population (Offredy 2008), the tool was seen as welcome. Although Parker (2006) commends the work, he questions the need for additional data. Rather, Parker concludes that the solution is far simpler requiring providers and purchasers to critically examine the extent and effectiveness of structures and processes supporting discharge, thus encouraging stronger links between acute and community health and social care organisations and professionals. Certainly with the introduction of transforming community services (DH 2009b) such developments may become apparent, in health at least.

Tremblay (2006) offered a critique of the PARR tool which questioned the ability of the NHS to meet demand that may be identified as a result of the tool. He also criticises Billings et al. (2006) for suggesting the design of appropriate interventions. Tremblay concludes that patients will be expected to participate and co-operate and thereby be pressured in what could be argued is a paternalistic manner.

5.41 Method for examining PARR data within study

Data provided by area 1 went back five years. This comprised millions of rows of data. However, the data had been added to in line with local needs and failed to offer as much within the study as had been hoped. This is discussed further in study limitations, section 5.8. In order to work with the data key decisions were made and the PARR data was examined in two ways:

1. Patients who had been interviewed as part of the qualitative exploration were cross-matched to their data on PARR. All the associated PARR data from these individuals was examined in relation to admission to hospital pre and post being case managed by a community matron.
2. With the reference group's agreement, a one year time span: Oct 2008 – Sept 2009 was examined in relation to the data set as a whole and applied to a larger sample.

For point 2 (above), this time span was chosen pragmatically because of the sheer volume of data which made working with 'the whole' a bigger undertaking than had been envisaged. Additionally, further decisions were made and an analysis of case comparison was undertaken to examine the journeys of those individuals who were case managed by a community matron and those who were not. Talking with clinicians allowed a decision on a PARR score of 70 being a common threshold for patients to be taken onto a community matron caseload.

The following hypothesis and null hypothesis were examined in relation to the quantitative PARR data:

Hypothesis: Patients, with high (70 -100) or medium (50-69) PARR scores, who are case managed by community matrons experienced fewer hospital admissions than those not case managed by community matrons.

Null hypothesis: There was no difference in numbers of hospital admissions between patients, with high (70- 00) or medium (50-69) PARR scores, who are *not* case managed by community matrons compared to those case managed by community matrons.

The following filters / exclusion criteria were applied to the data set:

- Excluded all patients not case managed between 01/10/08 and 30/09/09, all patients under 18 years of age, all patients with PARR score of less than 50
- Excluded all patients with insufficient data (24 patients removed)
- Excluded all deceased patients (49 patients removed)
- Excluded deceased patient who died within first 2 months of referral (3 patients removed)
- Excluded patients managed by other allied health care professionals (15 patients removed)

The two data sets provided as PARR data contained different fields and were cross checked by hand using patient's alphanumeric identifier which were common across both sets. This prevented double counting. The process identified 127 patients common to both data sets and who were case managed (Figure 18). A much higher than anticipated number of patients who met criteria for case management (over 18 years of

age, PARR score 50+, suffering a long-term condition at the named time frame 30/10/08-30/9/09) were found. These figures are displayed in Table 17.

	Case Managed Patients (includes jointly managed)	Not Case Managed
PARR high (70-100)	45	271
PARR medium (50-69)	82	625
TOTAL	127	896

Table 17: Numbers of patients identified from data sets: case managed versus not case managed despite meeting operational policy criteria for case management in area 1

Of the 127 patients who were identified as case managed, 21 were not managed by a community matron solely therefore they were excluded leaving 106 patients who formed the *intervention group*. Additional details can be found in Table 18.

106 patients were identified from the not case managed group (n=896) to form a *comparison group* (with no community matron intervention). Patients were selected as best matches to patients who were case managed by a community matron. Exact matches were not possible but each identified patient was matched on at least 3 of the following criteria:

- PARR score
- Condition
- Age
- Gender
- Ethnicity

Although exact matches could not be made the PARR score for both high and medium scores in the intervention and comparison groups only differed by 1 (table 18).

	Community Matron Case Managed Patients	Not Community Matron Case Managed Patients
	<i>Intervention Group</i>	<i>Comparison group</i>
PARR High (70-100)	Cell 1 1 (n=42)	Cell 2 2 (n=41)
PARR Medium (50-70)	Cell 3 3 (n=64)	Cell 4 4 (n=65)
Total group size	n= 106	n= 106

Table 18: Distribution PARR score across intervention and comparison groups

Cells 2 and 4 (table 18) were used to provide a matched sample from patients who were *not* case managed by a community matron; this group is referred to as the *comparison group*. The term comparison is used in preference to a control group, because the study is non-experimental in design (Polit and Beck 2004). This comparison group was compared to cells 1 and 3 who *were* case managed by a community matron and formed the *intervention group*. The sample was purposively created. Matching was undertaken as a means of dealing with extraneous variables. As Polit and Beck (2004) note, matching can be problematic. Researchers are required to know in advance what the extraneous variables are. In addition after two or three variables it often becomes impossible to match. This is completely in line with the matching process described above. There may, however be more than three variables present in a subject group. For the complex group of patients with co morbidities being investigated this was certainly true. Polit and Beck (2004) suggest an alternative: balance design whereby composition of the groups attempts to provide a proportional representation of extraneous variables. The conclusion from Polit and Beck (2004) is that pair matching (or balance design) is preferable than making no attempt to control extraneous subject characteristics at all. A critique is offered in relation to the data sets used in section 5.8: study limitations.

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Figure 18: Process of identifying intervention group: patients with a community matron (Randall et al. 2011)

5.5 Qualitative sampling and data collection

This section outlines the approach taken to recruitment of a purposeful sample of community matrons, patients, carers, managers, commissioners and GPs. It details the inclusion and exclusion criteria for each group and how recruitment was achieved. It then describes each sample.

Inclusion and Exclusion Criteria for Participants in Study

Community Matrons			
	Area 1	Area 2	Area 3
Inclusion Criteria	Individuals who had previously participated and agreed to re-use of data	Individuals who work as community matrons and either volunteered or were purposefully sampled	
Exclusion Criteria	Those who had previously participated but did not agree to re-use of data	Those who were purposefully sampled but declined	

Table 19: Inclusion and Exclusion Criteria for Community Matrons

Patients			
	Area 1	Area 2	Area 3
Inclusion Criteria	Previous participants able to be re-consented	Patients who are on a community matron caseload Patients able to give informed consent	Patients who have experience of a community matron (stand alone or virtual ward) Patients able to give informed consent

Patients			
	Area 1	Area 2	Area 3
Exclusion Criteria	Previous participants who have died or were deemed unfit by their Community Matron	Patients not on a community matron caseload Patients who are unable to give informed consent	Patients who have no experience of a community matron or virtual ward Patients who are unable to give informed consent

Table 20: Inclusion and Exclusion Criteria for Patients

Carers			
	Area 1	Area 2	Area 3
Inclusion Criteria	Previous participants able to be re-consented	Carers who have a relative who is are on a community matron caseload	Carers who have experience of a community matron (stand alone or virtual ward)
Exclusion Criteria	Previous participants whose relative had died as notified by CM	Carers who have no knowledge of a community matron caseload	Carers who have no experience of a community matron or virtual ward

Table 21: Inclusion and Exclusion Criteria for Carers

GPs			
	Area 1	Area 2	Area 3
Inclusion Criteria	None. Not part of study	GPs who sit on newly formed commissioning board/ contribute to commissioning in relation to LTC	
Exclusion Criteria	None. Not part of study	GPs not involved with commissioning of LTC services	

Table 22: Inclusion and Exclusion Criteria for GPs

Former Commissioners			
	Area 1	Area 2	Area 3
Inclusion Criteria	None. Not part of study	Commissioners who have experience of commissioning in relation to LTC	
Exclusion Criteria	None. Not part of study	Commissioners not involved with commissioning of LTC services	

Table 23: Inclusion and Exclusion Criteria for Former Commissioners

Managers			
	Area 1	Area 2	Area 3
Inclusion Criteria	Managers with knowledge of Community Matron service implementation, design and changes		
Exclusion Criteria	Managers with no knowledge of Community Matron service implementation, design and changes		

Table 24: Inclusion and Exclusion Criteria for Managers

5.51 Community Matrons

In seeking participants, I asked community matron participants of the original study if they would re-consent. Eleven out of fifteen did so (time in post 18 months to 5 years at time of data collection in 2010). The four former participants who did not re-consent did not offer an explanation why and as I had a good success rate and knew that I would also be collecting additional data I did not follow them up. From the two new areas, I asked for volunteers and seven community matrons offered to take part. In addition I approached three purposefully, because I wanted a mix of years of experience and got matrons with a range from 9 months to 8 years in post, in the cohort. This was to ensure I could examine their knowledge of service changes. Similarly, I purposefully sampled to ensure I had autonomous single-handed community matrons in area 3 as well as those who worked as part of the virtual ward. The virtual ward is a different model from the original community matron model as envisaged in 2004 (DH 2004a). I describe the VW in section 3.3. As Parahoo notes (2006) purposeful sampling allows the researcher to make judgements based on the knowledge of potential participants.

Interviews were arranged at mutually convenient times and places. Information sheets were sent out ahead of the interviews, allowing participants to consider the information. At interview day, participants were asked if they had any questions, prior to signing informed consent. All were reminded that they could stop the interview at any time without penalty. Following the interview, I purposely asked five community matrons if they would consider keeping an audio diary over a two week period. They all agreed to do so.

Case	Autonomous CM	Virtual ward CM	Years as CM (* in 2010)	Re-consent Interview & audio diary	New interview	New Audio Diary
Area 1:						
Natasha	•		4 years*	•		
Gill	•		2 years*	•		
Veronica	•		5 years*	•		
Heidi	•		3 years*	•		
Trish	•		18 months*	•		
Olivia	•		2 years*	•		
Lauren	•		2 years*	•		
Kate	•		18 months*	•		
Isobel	•		2 years*	•		
Megan	•		1 year*	•		
Joy	•		2 years*	•		

Case	Autonomous CM	Virtual ward CM	Years as CM (* in 2010)	Re-consent Interview & audio diary	New interview	New Audio Diary
Area 2:						
Julia	•		1 year		•	
Liane	•		1 year		•	•
Geri	•		1 year		•	
Anna	•		8 years		•	•
Ellen	•		5 years		•	
Area 3:						
Jess	•		7 years		•	
Lucy	•		7 years		•	
Sally	•		9 months		•	•
Liz		•	6 years		•	•
Chris		•	8 years		•	•

Table 25: Matrix of community matron involvement

5.52 Patients and Carers

Across both areas 2 and 3, as had previously happened in area 1, the Community Matrons were asked to mention the study to patients and carers. This was a specific requirement of ethical approval. The ethics committee were concerned about vulnerable individuals being contacted by a researcher who was not known to them. As the patients and carers had an existing relationship with them it was deemed appropriate for the community matrons to make the first approach. The community matrons were advised by the researcher about this. The community matrons were to ask patients and carers if they would consider talking about their experience of having a

community matron with a researcher (in area 1, who was evaluating the service and prior to re consent for use in the researcher's PhD; in areas 2 and 3 to a researcher undertaking doctoral study). Those patients and carers who wished to take part agreed that their contact details could be passed to the researcher who contacted them. A mutually convenient time was arranged for me to visit them. A brief description of what was required was given and then information sheets were posted ahead and informed consent gained on the day by the researcher after ensuring that potential participants felt aware of their role and were comfortable to continue. Such an approach acknowledges that gaining informed consent is more than simply reading and signing a form, but rather is part of a process that takes place over time and includes some human dialogue (Flory and Emanuel 2004). It was stressed to patients that if they were too ill to participate on the day, this would be managed. The interview could either be re-arranged or cancelled altogether. This happened with one lady, but the interview was successfully re-arranged three weeks later.

Case	Autonomous CM	Virtual ward	Re-consent for use of interview	New interview
Area 1: patient				
Harry	•		•	
George	•		•	
Pam	•		•	
Paul	•		•	
Area 1: carer				
Edie	•		•	
Dolores	•		•	

Case	Autonomous CM	Virtual ward	Re-consent for use of interview	New interview
Area 2: patient				
Maud	•			•
Ava	•			•
Area 2: carer				
Stan	•			•
Area 3: patient				
Arthur	•			•
Patrick	•			•
Rory		•		•
Ray		•		•
Area 3: carer				
Nina	•			•
April	•			•
Mary		•		•

Table 26: Matrix of patient and carer involvement in the study

5.53 GPs

Three GPs were recruited in total; all of whom had an interest or were part of the new commissioning groups. Two were in area 3 and one from area 2. Their recruitment came through various guises such as meeting through a training event and through the community matrons.

5.54 Managers and former commissioners

Managers and commissioners were purposefully sought in both areas 2 and 3. In area 3, the manager who was in post at the time of community matron service development

and a current manager were interviewed. The manager interviewed in area 2 was the current one. In area 1, the current manager (2010) was interviewed; she had not been in post at the set up of the community matron service. One former commissioner from both areas 1 and 2 was interviewed using a semi structured format. Both had knowledge of the introduction and changes to the services.

5.6 Access and Consent Issues

This section describes how access and consent were achieved in the three areas in which data was collected.

It has been noted elsewhere that this thesis is built upon funded work. As the original participants did not consent to their contribution being used for the purpose of my PhD, it was agreed with the funders and through a new ethics approval (REC Reference Number: 11/WM/0244) that re-consent would be sought for re use of the data. From the original site, 11 out of 15 matrons re-consented and four patients and two carers re consented. This number was lowered as some patients who took part originally had died or their condition had deteriorated such that the community matrons, who acted as gatekeepers, deemed it inappropriate that they be contacted by the researcher. Cree et al.(2002) notes that adults act as gatekeepers to children as a means of protecting them. Similarly it could be seen that the community matrons were acting in this role to the vulnerable adults in their care.

For the area 2, e mail correspondence with the Head of Nursing gained agreement for the study and I attended a meeting of the community matrons to explain the project and seek participants.

In area 3, the process of access was achieved initially by meeting with senior managers of the services involved. This allowed me to explain the project and its rationale and to give an overview of staff time involved in participation. As the study had ethical approval and research and development approval at the named Trust, agreement was gained.

5.7 Ethical considerations

As noted above, the research was bound by the Research Governance Framework for Health and Social Care (DH 2005d). The proposal was peer reviewed through the

University review process and was then submitted via IRAS (Integrated Research Application System) for consideration by a research ethics committee (REC) and relevant research and development (R and D) departments. The parent project gained ethical approval in May 2009 (REC reference number: 09/H1210/66). The doctoral study obtained ethical approval in August 2011 (REC Reference Number: 11/WM/0244)

As my study began as an extension of the parent project (see section 5.2) the same questions were utilised to all participants (in areas 1, 2 and 3). A new study title was used for the doctoral work differentiating it from the parent project. However, preliminary analysis of the new data in the doctoral study changed the thesis focus as the question of embedding came through. As a result, the title of the work changed again, based on analysis of data. The data collected remained from the questions reviewed by the ethics committee in August 2011.

In gaining ethical approval the following framework was administered. The four rights of participants in research as set out by the International Council of Nurses (ICN 2012), were paramount. The principle of beneficence, including freedom from harm was addressed. That confidentiality has been maintained is fundamental, providing that no breaches of the Nursing and Midwifery Code of Conduct (2008) were observed. Similarly for all participants, their ability to be recognised, by other people in data reporting, would be avoided. Where to gain further support if the research is upsetting was clearly laid out in the information sheets, as required by the ethics committee (see Appendix 6).

Principles of justice and right to privacy were considered, not least because this study required some intrusion into the private thoughts and attitudes of those taking part. Similarly, the principles of respect for human dignity, including the right of self-determination is important. A participant's decision to be a part of the study must be entirely their own and free of coercion. As alluded to above, recruiting patients and family carers through their Community Matrons requires sensitive handling. Parahoo (2006) states that there are a number of reasons why captive populations may wish to take part and those are: moral obligation, gratitude, fear of reprisals, fear of being labelled uncooperative and the need to conform. These ethical concerns were addressed by meeting the Community Matrons to discuss recruitment and the pitfalls of coercion

(RCN 2009), so that there is “uncoerced voluntary participation” (van Wisson and Siebers 1993). For patients and carers, the information sheet, written in lay language, and an appropriate language for the participant clearly stated how their information would be used, by whom it would be seen and the right to withdraw at any point with no fear of care being withdrawn. For this research, approaching potential participants in this way could be seen in terms of risk-benefit, whereby the approach by a trusted individual as the Community Matron to a vulnerable housebound individual, is less frightening for the potential participant, than being approached by a stranger. Informed consent (consent forms can be seen in Appendix 7) was obtained by the researchers prior to interviewing participants, with clear guidelines that participants are free to withdraw at any point without penalty (Parahoo 2006).

All data collected complied with the Data Protection Act (Great Britain Parliament 1998), ensuring the correct storage of data, access to data by the researcher and disposal and overall responsibility of the data.

5.71 Strategies for rigour

To ensure rigour within qualitative research, the four principles developed by Guba and Lincoln (1985) to enhance trustworthiness and widely cited by authors in qualitative research have been used. These are: credibility, dependability, confirmability and transferability. To enhance credibility triangulation has been planned through triangulation of location for data collection of qualitative data. For example, three trusts in three different geographical locations have provided community matrons, patients, family carers and managers to contribute to the study. Dependability refers to stability of data over time and conditions. The use of an enquiry audit (Polit and Beck 2006) whereby an external person scrutinises data and relevant documentation has been used in part, as this is a supervised project.

Confirmability refers to objectivity or neutrality of data. The use of a reflexive journal by me has been a means of achieving this outcome (Polit and Beck 2006).

Lastly, transferability of data, which is often considered difficult in qualitative research, has been considered (Long and Johnson 2006). By giving enough descriptive information

for the reader to make contextual similarities has been a means of showing transferability.

Although predominantly qualitative the use of a small quantitative data set means that the researcher has been mindful of rigour associated with a quantitative study. As such, aspects of quality in relation to quantitative work: reliability, validity, generalisability and objectivity (Polit and Beck 2004) have been examined. Reliability refers to the accuracy and consistency of data obtained in the study. The PARR data set provided a challenge in this respect because in area 1, some additional strands of data had been applied to meet local requirements. Validity concerns the '*soundness*' of the study (Polit and Beck 2004: 36) and the likelihood that results are sound and convincing. So alterations could be argued to be an internal validity threat which may affect the inferences made from the data (Creswell 2009). Table two shows the process by which data was chosen, but generalisability could be adversely affected by the local alterations made, and therefore be considered as an external validity (Creswell 2009) threat if taken beyond the data set examined.

5.8 Data Analysis

This section describes the data analysis approach for quantitative data and the inductive approach taken to analyse the qualitative data. It also sets out why I have used two different forms of data management for the qualitative aspect: a hand system and a computer package system.

5.81 PARR data (quantitative)

Consideration now turns to the analysis process for the quantitative data set. The small quantitative data set was analysed as follows: the nominal, ordinal and interval data were coded numerically. The intervention group was numbered 1; the comparison group numbered 2. PARR medium data was numbered 0 and PARR high numbered as 1. This was placed in the Statistical Package for Social Sciences (SPSS) version 20 (SPSS 20) for Windows (Chicago, IL, USA 2012). Distribution of the data was examined using a test of normality in the intervention group and the comparison group. Hospital bed days versus risk score were examined in both. As the data were not in a normal distribution non parametric tests were applied. Results are presented in chapter 4.

All analyses were completed using SPSS 20. Two independent samples were examined: the intervention group (intervention = on community matron caseload) and the comparison group (not on community matron caseload).

5.82 Practical steps (quantitative)

Having prepared a codebook which established variable names and coding responses these were then entered into SPSS 20. Variables were defined with consideration given to: name, type, width, decimals and labelling. Values were then assigned meanings. Data were entered. There were no missing data.

At this stage, Pallant (2001) stresses the importance of screening data to ensure it has been entered correctly thereby reducing the risk of flawed analyses at a later point.

I assessed the data for normal distribution in order to defend the statistical test to be used. Firstly the intervention group was examined in relation to hospital bed days and risk (PARR medium and PARR high). The same was explored in the comparison group. The Kolmogorov-Smirnov test was used. As the $p \text{ value} \leq 0.05$ the data was not normally distributed. The tables can be found in appendix 11. Transformation of the data was undertaken to see if this affected the data distribution. However, neither square root nor log transformation achieved normality in all group / risk category.

Histograms are provided in appendix 12. These show hospital days versus medium and high risk scores in both the intervention and comparison group.

Additional outputs can be found in Appendix 13. An interpretation of the outputs is provided in findings (section 6.53). As the data were not normally distributed non-parametric statistics were performed. As the samples are independent of each other a Mann-Whitney test has been used to test for differences between the independent groups. This is the non-parametric version of the t-test for independent samples. Instead of comparing the means of both groups (t-test), the Mann-Whitney U test makes a comparison of medians (Pallant 2001). As the scores are converted to ranks, the score distribution is of less importance.

5.83 Interviews and audio diaries (qualitative)

In collecting the qualitative data, largely through semi-structured interviews, analysis has already begun (Parahoo 2006; Polit and Beck 2004). Conducting interviews and listening as the data is imparted by participants meant that some analysis took place simultaneously with collection, making qualitative analysis both an active and interactive process (Crabtree and Miller 1999).

The dominant qualitative study and data analysis followed an inductive approach as described by Miles and Huberman (1994). Their model integrates four stages. These are: data collection, data reduction, data display and drawing conclusions and verification. As noted above, Miles and Huberman's model allows for data collection to be influenced by the process of data analysis.

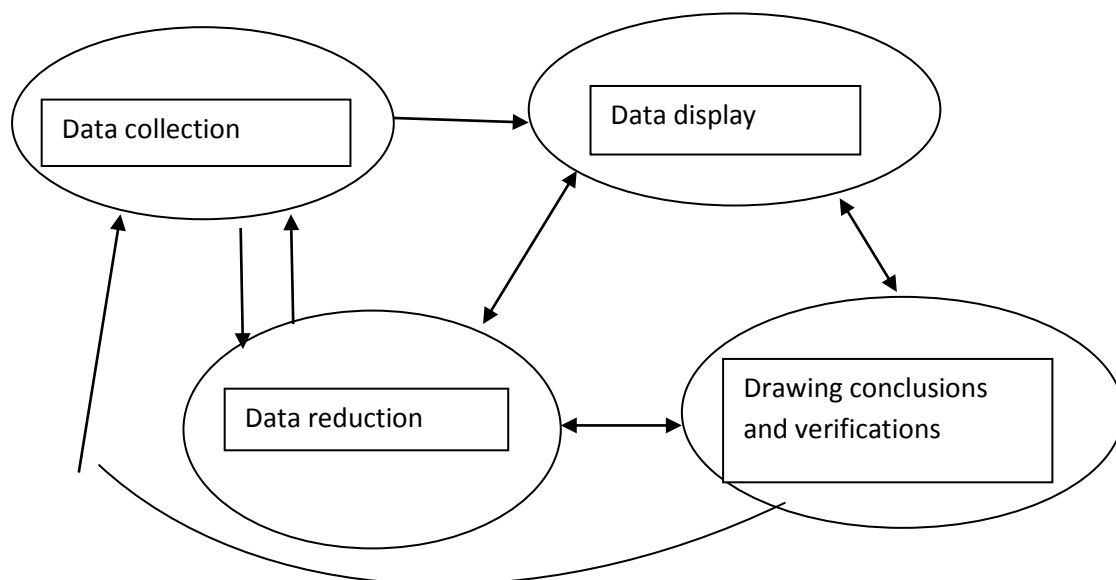


Figure 19: Model of data analysis adapted from Miles and Huberman (1994)

A potential difficulty in considering what data analysis framework to use for this study arises from the fact that the methodology used is not 'pure' in the sense of grounded theory or ethnography or phenomenology, but rather 'applied'. As noted previously, applied research is eclectic in the methods used, but that does not make it atheoretical (Thunhurst and Randall 2010).

With these factors in mind the framework used is that of Ritchie and Spencer (1994). This 'Framework Analysis' has been gaining popularity in health not least because it was developed for applied policy research (Lacey and Luff 2007). As my study builds on a piece of applied research and is underpinned by an approach of pragmatism, this seemed a good approach to follow. Additionally, Pope et al. (2000) state that there is often a requirement to link qualitative with quantitative data. As both approaches are used in my thesis, I have attempted to make links where I think it is appropriate. Although the emphasis on participant text and analysis is inductive, the consideration of a priori knowledge (from the original applied research evaluation) which can be coded from the beginning and then combined with new themes and concepts in the inductive process is another advantage of using this framework (Dixon-Woods 2011).

Essentially the Framework Analysis is built upon thematic analysis, but in addition it offers a framework which is systematic and offers a clear view of the process of analysis. As such Lacey and Luff (2007) note the usefulness of this to funders in applied research projects, but I can also see a synergy for my supervisory team and later examiners in relation to the steps I have taken to analyse data for my doctoral study.

The Framework Analysis comprises five steps:

1. familiarization
2. identifying a thematic framework
3. indexing
4. charting
5. mapping and interpretation (Ritchie & Spencer, 1994).

These steps are expanded and reported by Srivastava and Thompson (2009).

Familiarisation is a well-recognised step in qualitative data analysis as it relates to immersion in the transcripts. So for me the interviews and audio diary transcripts allowed me to become familiar with key concepts those participants have highlighted. The second step is identifying a thematic framework. Here *a priori* factors are present, but this should not prevent new ideas from emerging. Not only had *a priori* factors come from the literature, but also from data collection in the parent project. Ritchie and Spencer (1994) note the framework to be tentative, thus allowing change as analysis

progresses. As part of the doctoral process, the original qualitative data were re-analysed. Step three, indexing, allows data to be identified in relation to themes; for me this meant defining concepts (see appendix 9). The fourth step of charting allows the data identified in step 3 to be arranged in charts of themes. Although this requires moving sections of text from its context, the text must remain identifiable to the case in question. Lacey and Luff (2007) give two examples of charting: *thematic* for each theme across all respondents (cases) or *by case* for each respondent across all themes. As a point of organisation, the same order should be used in all charts (see appendix 10). The final step of mapping and interpretation involves analysis of key characteristics and interpretation.

5.84 Practical steps (qualitative)

Interviews, which had been recorded on an Olympus digital voice recorder, were transcribed *verbatim* and saved as word documents. Questions asked can be viewed in appendix 8. Audio files from the parent project were transcribed by my research assistant. In the second wave of data collection, larger files, those over 35 minutes, were transcribed by secretaries within a research group at the university and who had previous experience of transcribing. On receipt of the word files, I listened back to the tapes and cross checked against the word documents for accuracy and consistency. I particularly wanted to note how silences and hesitations had been documented. Some words with a health/medical terminology had been transcribed incorrectly such as ‘par’ for the PARR acronym (patients at risk of readmission). However as I had conducted the interviews, I knew the context and understood the difficulty for a transcriber who was not familiar with the numerous abbreviations used when health care professionals (in which I count myself) talk to each other. There were also occasions when the transcriber had not been able to pick up what was said by the participant. I was able to ‘fill in the blanks’ accordingly.

Organising and reducing the data is an important step in analysing the data (Rabiee 2004). For the smaller data sets: patients, carers, commissioners, GPs, Managers, a physical paper exercise was undertaken to analyse the data. This exercise comprised the following steps (and is illustrated in appendix 10):

- numbering lines and pages of transcripts to ensure tracking can occur
- reading transcript
- re-reading, making notes in the margin
- defining concepts
- introducing colours to margin notes to link similar concepts together
- Placing same coloured groups together
- Considering content and applying overarching theme
- Place into case grid

The data set from community matrons across the three areas was large. As such a different approach was taken for data management. As I see my PhD as research training I consider that it offers me a great opportunity to try different methods. As a consequence of this rationale, I chose to manage this data using a computer package, NVIVO 9 (QSR International 2010). I considered this at length and referred to the literature in order to understand the arguments for and against the use of computer packages in qualitative data analysis. The literature is presented below.

Computer packages for analysing quantitative data are well established, such as SPSS (Parahoo 2006). Since the mid-1980s, there has been a proliferation of computer packages for qualitative analysis (Morison and Mair 1998), but qualitative researchers have been slow to analyse data sets in this way (Shin et al. 2009). It has been suggested that a reason for this lack of enthusiasm is concern by researchers of not being able to be close to the data (Polit and Beck 2004).

Literature which considers the place of computer assisted qualitative data analysis systems (CAQDAS) considers the arguments for and against its use. Proponents argue that the use of computer packages frees up time to allow attention on conceptual issues (Ayres, Knaffl and Tripp-Reimer 2008). Most writers on the subject are keen to raise pros and cons and indeed Weitzman (2003) splits his chapter into considerations on false hopes and fears; real hopes and real fears.

Of false hope and fears, Weitzman (2003) considers that many researchers are still under the misapprehension that computer packages will 'do' the analysis, whilst others

are concerned that CAQDAS will take over the building of theory. Weitzman and Miles (1995) refute the latter claim, stating that programmes can only support researcher efforts making it easier to think more coherently about the data, which have been effectively managed. After all, a key element of qualitative data management is reduction, which allows subsequent analysis to be constructionist, although Polit and Beck (2004) note that enhancements in CAQDAS have led to some blurring in the data management and data analysis phase.

Real hopes of CAQDAS are that it provides tools for searching, marking, linking and re-organising data. In addition, Weitzman states that it aids consistency in finding all the places in the data where a key word, for example appears; speed and being able to search and re-search instantaneously; representation which allows maps and diagrams to be re-drawn; finally consolidation allowing all the data to be managed in one place and therefore cross referencing to be achievable in across the whole data set. The nature of data needs to be understood in the context of the tools offered by the different packages, as one size does not fit all (Morison and Mair 1998).

Real fears, as suggested by Weitzman (2003) are often the 'flip side' of real hopes. Two concerns which are highlighted by Lee and Fielding (1991) are that firstly, qualitative researchers may be tempted to report on findings which have been closed prematurely and secondly that the availability of computer packages may mean that inexperienced researchers do not understand the process of manual analysis, and the continuing importance of creativity as a part of qualitative data analysis. In considering the first point on premature closure, Ayres, Knaffl and Tripp-Reimer (2008) state that although the use of CAQDAS may increase the likelihood of premature closure, they have actually found the software systems helped to prevent premature closure and reduce bias. Being aware of possible pitfalls is a part of learning to work effectively with CAQDAS. Although software packages are quoted as a means of using time more efficiently in the analysis process, time to effectively learn about the package is a factor. This is an important consideration according to Fielding and Lee (1991) who consider the untutored use of software programmes could provide '*banal and off target analyses*' (1991: 8). The use of more readily available and better known packages such as Excel, which are also easy to

share and when used in conjunction with a framework technique can provide a middle way between specific packages and manual analysis (Swallow et al. 2003).

The main advantage of using a CAQDAS is in organising and being able to retrieve large amounts of data. In addition to the fears considered above, other fears are conveyed by Siedel (1993) who considers that insight is at risk of being sacrificed in favour of scope. Traditionally, qualitative studies have comprised small sample sizes. This has courted controversy from positivist colleagues, but CAQDAS could allow this to change. Agar (1993) concurs by stating that qualitative analysis should highlight inter-related details of a small sample rather than commonalities in a larger sample.

With this in mind, I wanted to use NVIVO 9 as a learning tool to manage my data and to produce some visual tools. The analysis remains a process undertaken by me.

In presenting my doctoral thesis, I am aware of various limitations of my study. Next, I offer the reader a critique of the limitations as I see them.

5.9 Study Limitations

5.91 Quantitative aspect

PARR data was provided by area 1. It became clear that data sets had been added to in order to gain additional data than that provided by PARR++ in line with local requirements. So, although the data sets were predominantly PARR++, additional data sets were included and the alterations mean that generalisation of the whole data set would have been compromised if compared to other areas. Had the data been pure in relation to the required data for PARR, it is likely that the quantitative section of the original parent project and the re-examination for my doctoral thesis would have been larger and arguably more useful. Instead the discussion is limited to a paragraph. This example offers considerable possibility for debate. In my methodology chapter, I summarised arguments for the use of quantitative data. In moving from positivism which took no account of reality to post-positivism which suggested that a critical examination of reality was required, yet fundamentally still required valid and reliable tools to be employed (Philips and Burbules 2000), it was hoped that PARR would be valid and reliable. However in an applied research setting the desire to undertake a robust

quantitative element of enquiry was marred by the practical requirements to make the PARR data set 'useful' on a local trust level. This meant an improvised analysis was undertaken in the parent projects and why I chose to re-examine the data for my thesis, albeit that I have still undertaken a 'simple analysis'.

In addition, the quantitative sample was purposive. Patient journeys were examined in relation to the patients who consented to be interviewed as part of the parent project in area 1. The larger sample was also purposive. This allowed the researcher to exclude certain factors. For example in one data set the data was presented by individual healthcare occurrence giving millions of rows of data. This had not been anticipated at the project inception so a pragmatic decision was taken to limit the data used to a one year period. Other exclusions included patients under 18, those with PARR scores below 50, those who had died within 2 months of the year chosen, those with incomplete data and those managed by additional HCPs other than community matrons alone.

As a power calculation was not performed, it could be possible to argue that the independent samples of 106 patients were underpowered. Although a statistically significant result is not found it is possible that I have not looked at a big enough sample to find it and that the study is underpowered. However, given the nature and direction of the findings it may be considered unlikely that greater power would have impacted.

5.92 Qualitative aspect

As part of the ethical approval to undertake this study (and the parent project) the ethics committee required potential patient and family carer participants to be approached by the community matrons. Arguably, the matrons may have chosen to tell patients about the study who they felt would show them in a positive light. I attempted to mitigate this by asking the matrons to approach individuals with whom they may have struggled to form a health enhancing partnership. One matron in area 2 was particularly concerned about the fact that not all patients are concordant and think really highly of the community matron. As such she approached two patients on her caseload who she felt would give me very different viewpoints. Both consented to take part and their views are incorporated in my study.

It is fair to say that the views of community matrons as portrayed by patients and their family carers are largely positive. This is in line with other literature. Other studies have not made it clear how patients were recruited, but similar issues may have been a factor.

Participants, especially GPs and former commissioners, were recruited purposively for their interest in the care of people with LTCs. This means that they are likely to have broader views on the issue of community matrons, and so the findings relating to them may be less generalisable to the wider commissioning community.

All these factors have implications for the generalisability of the findings in this doctoral study. The differences in settings, different service models and purposive nature of finding participants must be considered. I hope that the detail around each aspect will allow the reader to make their own judgement about how my findings may fit with their own experiences of a community matron service.

5.10 Chapter Summary

In this chapter, I have presented the methods used to collect data and the rationale behind these choices. Sampling and data collection has been described and issues relating to access and consent presented. The means of analysing both quantitative and qualitative parts of the study have been provided and limitations of the study offered and discussed. I have explored rationales for the use of two separate data collection methods for the qualitative methodology.

Chapter 6: Findings

6.1 Introduction

In this chapter, I present the findings as they relate to both QUAL and quan aspects of the study. A table is presented to show the changes which occurred over the time community matrons have been in post in the 3 settings used as the basis for my thesis (see table 27, section 6.1). This visual representation offers an overview of the difficulties faced by community matrons through service redesign, particularly in areas 2 and 3 and, as such, that the service and the role of community matron struggled to embed.

As I sifted through the qualitative data noting concepts and themes, I found the story evolving and settling into 5 themes. These are:

- *‘Agreeing ways of working without understanding’*: implementation of the role of community matron and effects
- *‘A little bit of extra effort’*: the delivery of health care by community matrons
- *‘Climbing Mount Everest’*: psychosocial aspects of living with a long-term condition
- *‘A jigsaw of care’*: the patient’s journey
- *‘I can’t walk away’*: the invisible role of the community matron

Findings from the quantitative aspect link into patient journey and more specifically the sub-theme of hospital admissions in section 6.53. A diagrammatic representation is shown in appendix 14. I begin by presenting the first theme.

Area	2004	2005	2006	2007	2008	2009	2010	2011	2012
Area 1									
Service characteristics and changes: Autonomous Practice (AP), Mon-Fri 9-5, domains of case management				Appraisal of service October 2007- December 2009 Including Home Care team					
Number of community matrons	1	2	3	5	13	14	14	†	†
Area 2									
Service characteristics and changes: Autonomous Practice (AP), Mon-Fri 9-5, domains of case management							Fast response started (2010) Hours extended 8-8 Mon-Fri Weekend 8-4 ¥		
Number of community matrons	1	1	6	6	8	12	11	11	11
Area 3									
Service characteristics and changes: Area 3 had three separate Trusts A,B and C					3 trusts amalgamate into 1 with Virtual Wards (VW) and Autonomous Practice (AP), Mon-Fri 9-5				
Area 3 Trust A					Total number of community matrons				
Service characteristics: Autonomous Practice (AP), Mon-Fri 9-5, domains of case management					VW 3 AP 6	VW 3 AP 6	VW 4 AP 8	VW* 6 AP 3	VW 6 AP 3
Number of community matrons	0	2	3	3	Total number of community matrons				
Area 3 Trust B					9	9	12**	9	9
Service characteristics: Autonomous Practice (AP), Mon-Fri 9-5, domains of case management									
Number of community matrons	1	2	2	2					
Area 3 Trust C									
Service characteristics: Autonomous Practice (AP), Mon-Fri 9-5, domains of case management			Virtual Ward (VW) introduced alongside existing AP						
Number of community matrons	1	2	VW 1 AP 4	VW 1 AP 4					

Table 27: Timeline for community matron service in 3 areas

† End of parent project no data *Virtual wards in Area 3 increased to 3 ** three community matrons assigned to professional lead roles

¥ Integrated community pathway established 2011 in Area 2

6.2 'Agreeing ways of working without understanding': implementation of the role of community matron and effects

In this theme, I present findings associated with the implementation of the role and the role itself which includes the background and skills of community matrons. Issues of reaching capacity on community matron caseloads are presented and how solutions introduced skill mix in some areas. Also described is how the implementation gradually encompassed integrated care, relationships with other health care professionals and the use of joint visits and finally issues pertaining to case finding and influences of commissioning and changes to commissioning.

6.21 Implementation of the community matron role

Commissioners and managers described numerous challenges as a result of the introduction of the community matron role. Initially these arose from the nature of implementation which came as an edict from the Department of Health and as such had to be implemented by community health trusts and had associated targets for recruitment attached. The timing for introduction of a new role was hindered by the provider / commissioner split which had resulted from a national policy directive.

The rationale for this new role was noted as clear, encompassing a need to reduce fragmentation of care for patients with complex LTCs, to reduce duplication, aid navigation of health care systems and to provide a single point of contact. Ultimately a reduction of the burden on the NHS was envisaged. A community matron in area 3, with intermediate care background, stated that the same patients came through intermediate care every 6 months or so as no one health care professional had an overall view of their care. Exactly the same point was voiced by a manager in area 2 and with this focus the role of community matron was introduced. But, as Miranda, a manager in area 3 noted, issues were met with limited enthusiasm as a result of the policy initiative coming from the DH:

'You don't embrace it enough, because you are told to do it instead of coming to your own conclusions.' (Miranda: manager, area 3, p 2: 44)

The hurried timings in which the new roles had to be implemented impacted the operationalisation of the new role of community matron (Jane, area 1). The pressure to meet the targets set by government resulted in limited vision and planning (Jane, area 1;

Miranda and Rachel, area 3; Ruth, area 2). Lucy, a community matron in area 3 also makes the point about hurried implementation:

'But then was that you know can you blame the PCT in a way because the government said you have got to have community matrons in post by a certain time frame so it's also difficult for the PCT as well. It's like a lot of things I think in the health service that we are told from the Government you've got to do this and have this but then there's not, there doesn't seem to be enough time or maybe the right leadership to take it forward properly' (Lucy: community matron, area 3, p1:23-29).

In fact, work had been undertaken by the NHS Modernisation Agency and Skills for Health who produced a paper in 2005 (section 1.16) which set out domains of practice that community matrons should work to. When interviewing the community matrons, questions were based around these domains. In area 3, one matron had come into post prior to the domains hence an *ad hoc* implementation was perceived. Community matrons interviewed in area 1 in 2010 were cognisant of the domains whatever their time in the role. This was in spite of not having an operational policy at first. In area 2, Anna, who had been in post 8 years, gave the following answer when asked:

'Researcher: When you first came into post, how much was that around the domains of case management?

S: It was all about case management and the service delivery and supporting the long term condition agenda' (Anna: community matron, area 2, p 4: 118-121)

The answer showed her ease at understanding the concept of the domains of case management. However, three other matrons interviewed had only been in post a year. One had previous experience of the community matron role and was familiar with the domains, but the other two seemed bemused when asked about them.

Similarly in area 3, Sally who had been in post for 9 months was only aware because of writing an essay as part of her Masters. Her confusion is apparent in this quote:

'Researcher: How do you think that you've implemented the domains of case management?

S: Say that one again?

I: The domains of case management, do they ring a bell with you?

S: In terms of?

I: The skills for health and modernisation agency document on the domains of case management, A to I?

S: It's something that to be honest I've read about and used in essay...' (Sally: community matron, area 3 p 3:109-114)

For other staff in area 3, their roles had started before the domains were introduced so initial implementation of the role did not encompass them. Despite limited knowledge of the document by newer matrons, when asked questions linked to the domains it was clear that the role of community matron did continue to revolve around the 2005 work albeit in a less obvious way than earlier in the life of this role.

The original vision from the DH spoke of community matrons as autonomous practitioners holding a caseload which would enable them to navigate the complex healthcare system and reduce admissions to hospital for individuals with long-term conditions. It soon became apparent to the commissioners, managers and GPs who participated in this study, and indeed to some matrons that this vision was flawed.

As noted these difficulties were impacted by how the role was set up , funding, and misunderstandings associated with the role. Once a patient was on a community matron caseload there appeared to be little impact on them. However the misunderstandings which were apparent between health care professionals about the then new role of community matron are likely to have impacted patients and carers in less visible ways. Aspects concerning the role proved a strong theme with 19 out of 30 participants mentioning aspects associated with role

According to commissioners, targets were manipulated to encompass local issues. This may or may not have been to do with funding as neither commissioner, nor three of the four managers interviewed were able to remember whether funding came with the posts or had to be found from existing monies. Frustrations associated with funding still exist and for one matron are linked to poor understanding of the role in 2012:

'my real frustrations is that outside of the community matron team people who don't particularly understand the role are agreeing ways of working because it seems to attract finance but without understanding actually what the role of the community matron is.' (Geri; community matron, area 2, p2:54-57)

Initially all three areas set up autonomous community matrons as envisioned by the DH. In area 3, placement of matrons was arbitrary and failed to address population need in relation to LTCs. This was considered by one of the managers in area 3 to be associated

with a major reorganisation which was to result in the merger of three separate trusts in area 3 into one. The result was that different targets for implementation of the role had been established in the three trusts and at amalgamation there was a disparity in the number of community matrons across the county which bore no relation to the need and deprivation of the population with the 'better off' area having most community matrons.

District nursing teams struggled to understand and grasp the need for the role of community matron preferring to work in a traditional manner despite the fact that many had been recruited from the ranks of district nursing. One manager reported resentment for the role. Following the hurried set up and disparities, poor understanding of the new role of community matron was mentioned frequently. Pre amalgamation in area 3, there had been limited attempts to educate and disseminate the role whilst in the south of the county which is known as area 3, this had been much more successful with the outcome of better acceptance of the role. As a result, in parts of the county GPs were not forthcoming with support for the role whilst in other parts GPs were noted as being 'champions' of the role as noted by a community matron in area 3:

'GPs who were kind of very keen to support and teach others were kind of oh don't want to know, who are you, you know what qualifications have you got and you know we are doctors and we've done all this training how do you possibly think you can do what we are doing' (Jess: community matron, area 3, p 1:27-30)

In area 1, there was no operational plan at all. This meant that individual post holders developed individual ways of working which they felt encompassed the role and included different referral criteria into the community matron service and as a result other services became confused about exactly what was on offer:

'the people that were putting them into post didn't truly understand the nature of what they were to be doing.' (Jane: manager, area 1, p1:31-32)

This affected the way the role embedded. A similar lack of clarity about the role was noted by Chris (community matron area 3):

'there is really no formal guidance on the role as it is in our organization' (Chris: community matron, area 3, p3:102)

This links back to the finding in policy associated with reduced understanding of the domains of case management as a working document.

How to get over information of a new role was mentioned by one community matron (area 3) reflecting her own experience of trying to grasp new roles:

'it's the same for me I don't understand a role, somebody can sit there and explain to me what they do but until you actually work with them and can see what they do, do you really understand it, ' (Lucy: community matron, area 3, p11:410-412)

District nursing was seen to be very different from case management, although a poor understanding of case management itself was seen by both managers and commissioners in area 3, which persisted and led to poor understanding of the role by GPs. One community matron in area 3 captured this confusion quite effectively, noting that different interpretation added to the confusion:

'It depends on how you interpret that role, I think there is a lot of discrepancies, a lot of people say well what's the difference between a community matron and a case manager'. (Lucy: community matron, area 3, p4:115-121)

Conversely, Emily (commissioner area 2) reported that the term case management added to clarity within her organisation. Case management was reported by all managers as proactive in its aims whilst district nursing had been allowed to become reactive (Miranda, Ruth and Jane). Several community matrons who participated and had come from a district nursing background could see the problem. Veronica (community matron area 1) said:

'I try and be proactively involved ...try to keep on top of things. The District Nursing service might be somebody who might be useful to be involved..the trouble is...I mean I was a DN for many many years before I did this job...the problem is they seem incredibly task focused so if it's perhaps a dressing that's been asked of them ...or specific care or activity they're fantastic... but for this lady where it's more an observation type monitoring support type visit, my experience is that they don't particularly get engaged very fully..(Veronica: community matron, area 1 audio diary p7:336-342)

This example from Veronica shows the ability to move from one role to another, from that of district nurse to community matron, but one manager (area 1) stated that some community matrons who came from a district nursing background were unable to change their role from reactive to proactive:

'I think for some people it has been very stressful...I think there are people who have risen to the challenge and have taken on additional levels of clinical expertise in a

stepwise approach and they've sort of built on the knowledge and skills that they've got and done it that way. I also think though that there are people who will never change and I think they are probably the more difficult people...I don't mean in my role as a manager sense.. but to get to acknowledge the difference between a district nurse and a community matron.'(Jane: manager, area 1, p 2, 50-55)

thus providing additional challenges in promoting the role when outside parties were unable to see a difference in role. This can also affect the way a role embeds.

Anxiety over role overlap was also noted and community matrons had developed different mechanisms for dealing with this:

'I think people get protective of their role' (Joy: community matron, area1, p 8:378)

That the community matron role should reduce some of this duplication continues to offer dubious impact as a community matron in area 2 notes:

'they will refer patients on but again I tend to find a lot of these roles start over linking and you've got COPD now that are actively following discharge patients and high risk admissions, so they now have somebody appointed to look at repeated admissions, which in one way was originally our role so.' (Liane: community matron, area 2, p 9:302-304)

How the role was set up, funded and misunderstandings associated with the then new role continue to persist according to the participants interviewed. It could be concluded that such factors impact the ability to embed a new role.

The implementation of the role and the effects of the role were, in part, affected by the skills and background of the individuals who came into post. Findings associated with these factors are presented next.

6.22 Skills and background

When the role of community matron was first initiated there was a lack of clarity about who should fill the then new roles. Miranda, a manager in area 3 notes that:

'what we were looking for when we went out to advert, we were hoping to get some acute nurses or some practice nurses with those skills. What happened at the interviews was that we got all community nurses; we didn't get any acute or any practice nurses apply & there was debate at the time about whether you could have Social Worker or therapist, but because it had matron in the title...' (Miranda: manager, area 3, p 1: 21-25)

The skills required to undertake the role of community matron did not exist in a large number of appointees and all areas reported a need to up skill the staff appointed to the roles. Perhaps the best initial set up and recognition of skills gap which was formerly

addressed was seen in area 2. Here, the first community matrons came from individuals employed as advanced nurse practitioners and six were placed with the six largest GP practices which spanned the three localities comprising the set up in the city at the time. In exchange for receiving a community matron it was expected that GPs would provide mentorship for advancing skills such as health assessment and prescribing, so the development of the matrons had a structure and worked in tandem with a formal university based education programme. A particular difficulty noted in area 1 was that when a large number of new appointees came into role at one time with a lower skill set than was required then the impetus was on educating them to the required level whilst still providing a service. This created tension between community matrons over the ability to be released for study.

Although most community matrons came into post with a degree, some had diplomas and they were actively supported to gain a degree. Those with degrees were generally supported to gain masters qualifications. From the participant interviews, areas 2 and 3 appeared to feel better supported than community matrons in area 1. There was also a difference in those individuals who had come into post in the first wave and had been well supported with educational needs versus those who had come in later:

'I do have issues that it's not very easy to gain access to training ... and I think because the team has changed so very much over the last 2 years that the.....and a lot of the matrons that have been here since the beginning have had their access to everything you know...HF courses, COPD courses, prescribing, LTCs course, one's done a Masters...and that was sort of the basic training that was expected and they got that without any argument and full support whereas now it feels as if it's like a lottery post code system' (Lauren: community matron area 1 , p2:63-68)

This comment by Lauren is a community matron who came into post in 2008 (interviewed 2010) and can be contrasted with a community matron who was appointed in 2011 in area 3:

'I was then advised to do the long term conditions degree and then was transferred onto the masters program and the trust I work for have been fully supportive, although not been brilliant with study time' (Sally: community matron, area 3, p 1:21-22)

Having appropriate skills to undertake the role of community matron was seen as part of the value of the service by commissioners. Largely, the commissioners interviewed saw a value in the role of community matron. Advantages were noted as skills in assessment,

ability to motivate patients to self-manage, awareness of local services, and understanding the progressive nature of disease without being a specialist. The last point was reiterated by Emily, (commissioner area 2) who suggested that the value of community matrons was their:

'community experience which allowed them to coordinate rather than to be disease specific'. (Emily: commissioner, area 2, p5:184-186)

The need to link with specialist nurses who were disease specific was noted as important, however and this comment links the clarity of role for one community matron in area 2 and also the boundaries of her role and needing to seek additional help at times:

'So for me I am quite clear about what my role is in relation to the holistic care of patients with long term conditions and the fact that my main role is to prevent hospital admission but also to improve their quality of life, but I am also very clear about where I need to refer out to different disciplines so that I don't become the complete provider of care to a patient where actually I am there to manage their long term condition.' (Geri: community matron, area 2, p 3:122-127)

There is a confidence about this answer which does not show anxiety in role blurring or boundaries, perhaps because managing the patient with a LTC sits at the heart of practice.

The background of community matrons does seem to colour the way the service is seen. As noted district nurses are reported as struggling to embrace the role. This is noted by former district nurses and this quote from Chris (community matron area 3 and former district nursing sister) shows her reflection on this issue:

'But it's recognizing the difference and the level of assessment that I would've done as a band 6 and then going into the community matron role because actually you don't know what you don't know so you think you're a very good nurse doing a holistic assessment, I wasn't doing a holistic assessment I was doing a holistic assessment within the realm of my knowledge and competency at that time and it's only on reflection now when I look back, I work very differently now as how I worked as a band 6 district nurse, but of course you don't know that at the time.' (Chris: community matron, area 3, p2:82-89)

However knowledge of working in the community is noted as important in the role as a community matron in area 1 explained:

'I think the only things that we lack a lot is knowledge about the medicines and about some of the conditions cos we're not used to COPD, asthma that kind of thing but we're you know...we're quite familiar and quite au fait with community services..all the

different services that are around ..community work and seeing patients at home so I think everybody brings with them different skills and different experience.’ (Megan: community matron, area 1, p1:18-22)

In contrast, a community matron who had previously spent her career in a hospital setting did acknowledge taking time to settle into a role in the community and particularly working with patients in their own homes:

‘I didn’t have a good handle of understanding how long to leave patients between visits and that was something I had to learn and that comes with confidence in managing conditions, and so if someone exacerbates on a Monday you don’t necessarily have to go and see them on a Tuesday or a Wednesday you can actually do telephone contacts you can do other things and that helps you manage your time.’ (Julia: community matron, area 2, p4:155-160)

Those individuals who come from different backgrounds, such as acute, intermediate care, specialist or practice nursing do not always agree. For one former specialist nurse turned community matron there is actually an added sense of freedom over and above colleagues whose background was formerly that of district nurse:

‘I think one of the positive things that I found is I’m not from a district nursing background, so I’m not caught up in well that’s something I should be doing, because it’s thinks some of the role for example I don’t know continence care I don’t know how to do it, well you know I’m not qualified to do it, I’m not going to do it, it’s not part of my role. Whereas I think for matrons that have come with that background, they have, they feel they have an obligation to do it so I think I’ve been much clearer in what I see the role being, and I think that’s influenced some of the other matrons.’ (Liane: community matron, area 2, p 1:17-24)

For community matrons who came from backgrounds other than district nursing, they were keen to explain the skills they had developed in their careers as being transferrable thus making them suitable for the broad role of community matron:

‘I’ve had a lot of experience in intermediate care, which I don’t think is too dissimilar to this role, cos you case manage a patient..intermediate care and work proactively than reactively...’ (Kate: community matron, area 1, p1:4-6)

‘I was working in intermediate care prior to this role which I feel was very similar because we looked very holistically at patients rather than at the pure nursing model.’ (Lucy: community matron, area 3, p1:3-4)

‘I’ve done acute experience as well as acute elderly care experience, which I personally think has really enhanced my ability to do the role well because you can understand what happens when a person becomes unstable as well as what to do about the long term management of those patients’ (Gill : community matron, area 1, p1:40-41)

In addition to transferrable skills, it is interesting to note how one former specialist nurse saw her previous role, and how her role could be expanded. Incorporating palliative care into that role allowed her to see a new version of the reality of living with a long-term condition that had not been seen by her previously:

'I worked very much as, well I was a heart failure nurse specialist I've worked very much in acute care but in a specialist role and very sort of narrow vision really more just focusing on sort of the acute management of heart failure, and then throughout the time I was there I wanted to start expanding the role so it took on more of a holistic approach.... because once I'd done that palliative role I couldn't go back to being as narrowly focused on specific disease illnesses and it made me want to be a community matron,' (Liane: community matron, area 2, p 1:4-7)

These personal insights and qualities are likely to have an effect on the delivery of a role particularly if there are limited guidelines as to how the role is set up. Having presented findings associated with previous backgrounds and skills, I will now present findings linked with advanced nursing skills seen as important for the role of community matron.

When asked about advanced nursing skills all the community matrons who participated mentioned three aspects: physical assessment skills, non-medical prescribing and holistic assessment. These skills were also mentioned by the managers who considered that these skills helped to keep individuals with complex long-term conditions in their own homes, often bypassing the need for GP involvement altogether, thus reducing pressures on GPs. As one noted:

'the matron is better at chronic visiting, has more time to do that & so they are probably done to a better standard.' James: GP, area 2, p2:33-35

In turn patients and carers felt this had an impact on their use of other services, reporting less usage of GPs and A&E:

Last year I think she had it about 3 times (transient ischaemic attack [TIA]) and she didn't go to casualty none of them' (Dolores: carer, area 1, p 6: 211-213)

There was also acknowledgement of greater time span between CM appointments in periods of stability in patient's health:

'well it used to be once a week, but now it's every 2 weeks or even 3.' (Harry: patient, area 1, p3:65-67)

Value was also placed on the ability to undertake a holistic assessment which encompassed a wider perspective of this vulnerable patient group. A community matron explained holistic assessment as follows:

'How effective am I, I think I have got a good holistic head so I do have this holistic attitude to care and so it's not just about treating the actual medical presentation of the condition, it is not about just treating the chest infection it is looking at all the other stuff, the social stuff, it is looking at how they're psychologically adapting to living with the condition, is there any therapy or rehab goals that we can actually work on and bring in a different discipline to help them to achieve theirs, so I think I have got a good head around that' (Julia: community matron, area 2, p 4:149-154)

Stronger links had been established in one area for referrals to psychology services and it was noted that community matrons made good use of this pathway. In turn this enhanced the community matron service. As one manager in area 2 described:

'some of it is perfectly normal, some of it they do need to be in hospital, a lot of it is psychological or there's mental health issuesI think it's starting to help us understand more those patients and why, why they present with what they present really so.' (Ruth: manager, area 2, p 8: 297-310)

Some matrons favoured other skills as well, although arguably skills which overlap those mentioned. For a matron in area 1, important other skills included:

'observational skills I think are important, interpretative skills ..and analytical skills and I think that's important, but as well as that I think the communication and relationship that you have with ..from one human being to another' (Heidi: community matron, area 1, p1:5-8)

Although technical skills such as prescribing and differential diagnosis are mentioned a lot in relation to working as a community matron, 'softer' skills such as those mentioned by Heidi were also noted by other health care participants. The usefulness of case management in promoting self-management and partnership working was acknowledged as a valuable tool by managers in areas 1 and 3. That patients and their carers felt supported was widely acknowledged by managers in all areas.

Communication skills and support for patients was also seen by GPs. Lyn in area 3 states:

'it has supported my patients very well & it has given them a lot more confidence' (Lyn:GP, area 3, p 1:4-5)

This had, in turn, made many patients better self-managers (which will be explored from a patient and carer perspective in section 6.57). Commissioners also saw advantages in relation to skills in assessment, ability to motivate patients to self-manage and awareness of local services.

Despite many positives being described by participants, case finding appropriate patients who would benefit from the case management approach provided by community matrons proved challenging and this is explored next.

6.23 Case finding of appropriate patients for case management

As a means of making the role of community matron work, in line with national policy directives there was a recognised need to 'find' the right patients who would benefit from case management. Veronica (community matron area 1) notes the challenges in relation to case finding:

'but the most challenging thing,....no one of the most challenging things I find with case management is finding the right patient to start with.....' (Veronica: community matron, area 1, p5:248-250)

This proved and indeed is still proving a challenge, as described by participants with backgrounds as commissioners, managers and community matrons. PARR data were noted to be cumbersome to use (Miranda, manager area 3), fraught with misunderstandings (Jane, manager area 1) and one manager felt they were partly to blame for the insular way in which community matrons worked (Ruth, manager area 2). The data were noted to be out of date and did not encourage a proactive model and were not popular with community matrons in any of the three areas where frustration and disappointment was described:

'we used to have the PARR data but the PARR data was way out of date anyway and you used to go into the PARR data and look and then think well actually that patient died 6 months ago and that's just come through so'. (Ellen: community matron, area 2, p6:206-207)

Another model, BUPA Health Dialogue was used in area 3, but with a change to the tool, it was deemed less effective:

'not now no, the BUPA health dialogue was our biggest tool and for the pilots for about 18 months it was really useful, really good till they changed the tool, it became more of a cost tool so you'd become very high scoring if you were high cost which actually there are many high cost patients' (Chris: community matron, area 3, p 8, 315-318)

As a result of problems with case finding persisting area 3 has been working with their information department to create a more suitable method of identifying patients for case management. This challenge has also meant that patients lower down the risk stratification are actively considered for case management as being those with whom a

greater impact could be seen in maintaining their diseases rather than a concentration with those individuals who near the end of their disease trajectory and so life. The benefits of this are mentioned by Heidi, community matron in area 1:

‘so I’ll have people that have a PARR score of 20 but those are the ones that I wanna make sure I’ve already got all the services in place and there’s no excuse for them to access it...’ (Heidi: community matron, area 1, p 9: 422-423)

There is reliance, therefore, on other health care professionals providing referrals to the community matrons:

‘But to be honest with you we’ve got that many referrals coming through from specialists, we get them from specialist nurses as well, so the specialist nurses, the GPs and [hospital name] we’ve got more than enough, we’ve got more than enough, we’ve got a waiting list at the minute.’ (Ellen: community matron, area 2, p 6:208-211)

This is noted as *ad hoc* and dependent on relationships with GP practices and other professionals and their ability to understand the role and referral criteria. This is explored further in section 6.24.

The issues with capacity were seen as important by commissioners and managers in particular. Additional national drivers such as delivering care closer to home meant that changes to the service delivery model for community matrons was a requirement to meet this expectation. How these issues were overcome and changes to the models will be reported under patient. I will now return to the issues of capacity on caseloads. Findings associated with capacity are described in relation to how the community matron services were set up from national directives. It also considers specific issues when the organisation of care did not work out as well as that envisaged.

6.24 Capacity of community matron caseloads and changes to service delivery models

Capacity issues in relation to caseload size were expressed, as a flaw. Chris (area 3 CM) said:

‘There is caseloads sort of limit of 50 which is a figure that the Government decided on and the PCTs haven’t really altered’ (Chris : community matron, area 3, p3:94-95)

Similarly in area 2:

‘We at the moment case manage patients, most of us have got around 30 up to 40 patients on our case loads, we’ve got level 3 patients and level 2 patients,’ (Ellen: community matron, area 2, p1:21-22)

This affected the credibility of service by community matrons in several ways. In being autonomous practitioners, the community matrons had limited availability and there was no one to answer their phone when they had a day off (Jane, manager, area 1). Holiday cover was provided by district nursing who did not have the skills to manage patients with complex long-term conditions in their own homes and so patients were frequently admitted to hospital defeating the purpose of the community matron role (Miranda, manager, area 3).

It was acknowledged that caseloads soon became full and static (all managers). Agreeing this fact, Rita, a commissioner in area 3 stated:

'It was a bit of a log jam really' (Rita: commissioner, area 3, p2:56)

Capacity on caseloads was reached meaning new referrals could not be accepted and the service became inequitable as it was not available to all those in need of case management. This compounded the problem of poor experience when a referral was made only to be met by a refusal to accept as mentioned by James (GP area 2):

'GP: I think.. my perception and I'm not an expert but my perception is that the CMs all have a workload & they are all saturated & there needs to be a really formal active mechanism for taking people off their caseload, so that we can put new people in. My impression is that people don't easily get stepped down to the DNs so they hang on to lots of people on the caseload and then there's a blockage in getting people seen by them. That's my perception.'

Res: um

GP: I mean when I have referred people to the Matron they'll say oh yes that's fine but I can't see them for 2 weeks, because they have got so many other patients type thing.'
(James: GP, area 2, p2: 38-45)

Such issues as capacity are fundamental in changes being made, which can then impact on embedding of the role.

Autonomous community matrons were asked to hold a caseload which typically comprised 40-50 patients although in area 1, one community matron held 100. On investigation, she covered some residential homes and included these residents in her caseload numbers. Such numbers on a caseload could be deemed reasonable depending on the number of patients available to be case managed (bearing in mind the difficulties noted in case finding appropriate patients) and the number of community matrons in

post. Additional factors such as deprivation needs would also impact. In the quantitative findings, (presented in greater detail in section 6.53) which explored a matched sample of 106 patients who were case managed by a community matron and the 106 who were not case managed by a community matron, but based on similarities could and should have been case managed.

What is being considered then may be termed systems issues. The following data quotes note the challenges faced by community matrons:

'I am a standalone community matron that covers 4 practices in 1 town, 1 in a smaller town and 1 in a village. But it's just me so I liaise with the district nurses but I can't go and visit 3 or 4 times a day because there's only me over a very wide area and I have to plan my visits and you know plan who I'm going to see in a non-urgent way. Now there's the odd urgent case if someone phones and I'm in the area I can pop in but I can't sustain that so I am much more education advisory support role and I am using clinical skills but I am not doing that intense nursing support that is done either by the district nurses or unfortunately people still have to go in because there's not, haven't got the team, so I'm a bit of a lone worker, well I am a lone worker.' (Sally: community matron, area 3, p2:54-63)

Equally, what Julia (community matron, area 2) describes is broadly about capacity issues and how having the wrong service delivery model in place can impact efficiency:

'helps you manage your time and that helps you manage your capacity because that allows you to have visits for other people rather than just a select few, with case management it is about managing your time because you can't produce a gold standard service just for a limited number of people, you have got to produce a quality service for a number of people, you have got to be effective to the population as a whole not half a dozen gold standard if you like, that is my interpretation of it and that's, you know, that's what I think Commissioners want, they want us to be effective to whole group of people not just a select half a dozen making a massive difference to them.' (Julia: community matron, area 2, p4: 159-167)

Again, such a comment links with the quantitative aspect of the study in relation to the numbers of individuals found in area 1 who had three matched criteria the same and yet had not been case managed. As such, some individuals could be seen as receiving a 'gold service' in area 1 whilst many with similar need received none. In areas 2 and 3 where data was collected at a later date, such difficulties were addressed through changes to service design and therefore changes in the community matron role were reported by managers since the inception of the community matron role in 2005. Jane, the manager in Area 1 also noted changes in role which came from the implementation of an organisational policy on service delivery which had not previously been in place.

One of the key developments reported was around integrated working. The three managers interviewed in 2012 from areas 2 and 3, all reported an impetus around an integrated model. The manager who had been interviewed in 2010 had seen this as an important requirement:

'I think being joined up for me is one of the keys; we need to be more cohesive, more integrated.' (Jane: manager, area 1, p12: 463-465)

Largely, the driver behind integration appeared to come from the capacity issues. In area 2, the Primary Care Trust (PCT) (then one body prior to the provider /commissioner split) had attempted to embrace an integrated model from the original community matrons coming into post. This had not been successful, but an integrated community pathway had been re-established in 2011. This plan has community matrons, therapists, district nursing, psychology and fast response (formerly intermediate care) working side by side. Liane, community matron in area 2, notes the tensions which still exist about integrated teams:

'people are still very busy they tend in their own little areas still, so you've got the district nurses in their huddle and you've got the OT's and Therapists in another and the matrons sort of alongside' (Liane: community matron, area 2, p 3:88-90)

As part of the community pathway in area 2, the manager reported that any team member could be co-ordinator and capacity was increased by patients with complex long-term conditions being 'stepped up and down' as their conditions exacerbated or stabilised, but as described in section 6.22, DNs often did not have the skill set to manage 'step down' patients, partly because of large workloads which have made the service reactive.

Similar integration was noted in area 3 with care continuing across traditional boundaries and away from 'silo working' (Rita: commissioner, area 3, p4: 146-148). The inclusion of practice nurses in the plan, for those whose health improved enough for them to go to the GP surgery was also encouraged. It had been noted by commissioners that the provider commissioner split had led to fewer conversations with clinicians and that most conversations had gone through contracting. Therefore, a positive impact of the emergence of CCGs was the re-opening and re-engagement with GPs. Integration

was noted as important for the newly established clinical commissioning groups who saw this model as a priority.

In area 3 managers and commissioner described integration that had come at the end of a staged process of change. Initially capacity issues had been dealt with by the introduction of pilots for a virtual ward (VW) project. The term virtual meant patients being cared for in their own homes rather than in a formal hospital building but other perceived benefits of hospital care was 'part and parcel' of the virtual ward experience. These included care by a group of health care professionals (GP, therapists, nursing) according to need. It included skill mix within the nursing team and the ability to discharge patients from the VW back to traditional GP care once an exacerbation had settled. The community matron leads and assesses patients as part of this model. Advantages of the VW such as the ability to provide numerous visits, are noted by an autonomous community matron who states:

'One model is the virtual ward which is in some areas but not mine, and that is where you've got community matrons leading teams of case managers and staff nurses in doing fast response, intensive response for keeping people at home who are have exacerbations with their long term conditions or who are early discharge and they can then go in 2-3 -4 times a day to support people the matrons are prescribing whatever medication is needed and they are managed very tightly.' (Sally: community matron, area 3, p 2:49-54)

The amalgamation of community services with the local acute trust had lead to direct pathways for discharging patients from hospital and a greater understanding between the formerly separate organisations. Having a skill-mixed team had meant that patients with higher acuity could be discharged from hospital to the virtual ward rather than would have been the case with autonomous community matrons. Although the pilot of VW had led to permanent establishment, VWs did not cover the whole county and some autonomous community matrons still exist, so managers struggled with a two tier model of service delivery with continuing challenges and Rita, the commissioner in area 3 also noted the less than ideal situation of having two service models running.

Seemingly, GPs interviewed saw the virtual ward model as being maintained in the future, because capacity issues had been relieved with response times to referrals being noted as timely. However, GPs did comment on confusion arising from change in model

of service provision from single community matrons to virtual ward. This change, which affected the embedding of the community matron service led to misunderstandings of whether referrals should go to the CM or the VW as there was a lack of clarity of the integrative nature of the new service and that CM and VW had become synonymous, although there was acknowledgement that *'it seemed to be the same people'* (Sophie and Lyn, GPs area 3). This level of confusion for GPs was similar in relation to changes in area 2. A change which preceded the integrated community pathway was the incorporation of community matrons into the fast response service, which extended working hours from 8am to 8pm and included a community matron being available at the weekend. Although this change was partly instigated from the community matrons being graded an 8A and there being a need to utilise their skills further, the fast response role is reported as not working as hoped. Rather than receiving new referrals who could be turned around from hospital admission it had actually been utilised by other matrons to flag up individuals from their caseload who were exacerbating. However, GPs (and other HCPs) became confused by the changes as Anna (CM area 2) notes:

'When the role was first set up and the new service, GPs or health care professionals were on the intranet and faxed information about the new service but I know the doctors would phone me saying what's fast response about, what's this service, what's that service and I then went round to all the practice's to talk about the changes and also gave them the headed paper highlighting the different numbers to promote communications and there's constant change and health care professionals are struggling to keep up with what's available and what service is out there.' (Anna: community matron, area 2, p3 :93-99).

In a fast changing NHS, continued changes to services and roles can be seen to slow down efficiency, even if the vision is one of making improvements. This in turn affects how a role is allowed to embed. The introduction of the virtual ward has taken time to establish. GPs in area 3 commented that it felt underused yet offering great potential and that skill mix and extension of hours was a welcome change. However, concerns were also mooted about lower levels of skills and experience as a result of skill mix. The knowledge and expertise of the CM was in sharp contrast to some VW staff particularly in relation to nuances of prescribing and disease knowledge:

'When I interact with our CM, I know that she understands what I am saying so and I understand what she is saying and I feel I can talk to her on a sort of peer level whereas

sometimes I will get some of the VW nurses who I think... well that's not the most appropriate thing to do next, so I do have some issues about that. I think this is a sort of 'in process'. They've got to get up to speed and I'm assuming it's very new to a lot of the VW staff. You know it must be quite daunting.' (Lyn: GP, area 3, p2:52-57)

This is in line with results from a study into decision making in prescribing by nurses which suggested they often failed to find a suitable pharmacological solution, preferring to refer to the GP (Offredy et al. 2008a). What can be seen as a major change in service delivery shows teething problems which need to be backed up on an organisational level to ensure that the new system is embedded. This support would include training and education to meet expectations of roles within the VW. Another change which accompanied the VW was one of discharging patients. In addition to additional hours and a larger skill mixed team, having a discharge pathway has also been a means of improving capacity. Although as Chris (CM on VW, area 3) notes:

'so we discharge them if they're stable at 12 weeks, although we don't use the word discharge with them anymore because they got quite upset about that the patients so what we say to them is you're stable you don't need us to be visiting you anymore at the moment, so our routine visits will stop, however the moment you feel your chest is deteriorating or say in the heart failures you start to gain weight, or your more breathless etc, etc, you've got your plan, you know how to recognize you're deterioration, we want you to ring us straight away and we will come back out.' (Chris: community matron, area 3, p4:158-164)

A carer acknowledged the change in discharge arrangements, showing anxiety and noting:

'but once or twice they have said that they are discharging you, haven't they & they say you are on your own for a bit and it's a bit daunting, because it leaves a big responsibility to the carer, but they are on call and so I mustn't put them down for that & they have extended their hours too because I think they used to be 9 to I don't know, 6 or 7, but now I think it is 8 – 11 or something.' (Mary: carer, area 3, p2: 48-50)

For Chris, community matron in area 3, this is a part of promoting independence and not an over reliance on the VW. This change was not well accepted by community matrons who had been in post from the role's inception. As it impacted quite heavily on some matrons, data pertaining to the issue are explored under the theme invisibility (section 6.6) and sub theme of emotional impact (section 6.62) on community matrons.

As a result of capacity problems and subsequent changes to service delivery models, skill mix was introduced. Findings which relate to the use of different grades of staff are presented next.

6.25 Grade of staff

The comments here are provided by GPs, community matrons and a carer. One of the GPs considers that aspects of the community matron work could be:

'done by somebody else lower down the chain so to speak.' (James 2: 55-56)

This would appear to reflect a conception that community matrons are an expensive resource. In area1, 3 health care assistants had been employed to monitor patients deemed stable. This enabled community matron time to be freed up and used to assess acutely ill patients and to free up room for new referrals. Another GP sees this as an advantage of the virtual ward model:

'now that it's virtual ward, because there is more skill mix in the team, so that they can provide other things (Sophie: GP, area 3, p2: 57-58)

However, with the skill mix, particularly in area 3, there are some concerns in regard to the amount of experience and skills held by staff even at bands 5 and 6. It also hints at emotional impact which comes as part of the responsibility held by community matrons.

'I think that's the biggest problem having seen it with the band 5's and band 6's is when they haven't got those qualifications and those skills to actually keep an acutely ill person at home is quite a challenge..... if I increase my visiting you know and re-evaluate with each visit I can keep this person at home or you know if I think oh yes I'll keep them at home but then actually something terrible happens between that visit and my next visit, you know how am I going to stand up in a court of law and justify why I didn't get that patient admitted so it's quite you know, it is quite a big deal and you do need to be confident and have the knowledge to underpin that confidence, so that's quite a big ask.' (Chris: community matron, area 3, p8: 326-338)

For Liz, the situation of skill mix is more far ranging and encompasses a fundamental and negative change in role:

Sadly I feel that our role is being watered down. They expect nurses with less skills and less knowledge to do it & I think this can be potentially dangerous & I really don't think it's of benefit to the client particularly people with LTCs. (Liz: community matron, area 3, audio diary: entry 52)

Although most patients and carers who participated did not notice any difference in the care they received, one carer did. If her husband was ill she had worked out that he

needed to be seen by someone with appropriate skills and states:

'and some auxiliaries; some at the lower level. The ones who don't use stethoscopes, because if Ray, if I think he has got a chest infection, I always say send somebody with a stethoscope.' (Mary: carer, area 3, p3:71-72)

Having explored fears, concerns and positive impacts of using different grades of staff to manage individuals with long-term conditions, I now turn to the vision of how the introduction of the role of community matron was expected to work and the realities of how it actually did.

6.26 Integrated Care

A vision for the future encompassed a need to provide an operating system which worked as a whole and offered integrated care. This was noted as being in line with national policy drivers although only one specific policy was named. One manager particularly noted the benefits of the amalgamation of a community trust with an acute trust as a result of Transforming Community Services (DH 2009b):

'We are starting to get links with the clinical specialists at the acute hospital as well & we are even talking about a consultant outreach model for COPD. We have had to come a long way on getting the consultants on board in the acute trust working with them for the last year. It was seen to be taking activity away from them; their pts being looked after by community staff, not trained particularly in LTCs. Once we started to sit down with the specialist nurses & consultants and when they realised that our teams had been doing the same training as the clinical nurse specialists (CNS) to the same level at university, it took the barriers down and moved upwards'. (Rachel: manager, area 3, p3:111-116)

Thus presenting a positive outcome associated with a national policy, which arguably also reflects on the local implementation which familiarises other colleagues with the role. In area 2, there had been an attempt at the service set up to integrate the then new community matron service with district nursing. Both managers and commissioners noted the failure of this plan, not least because of organisational change and change of leadership. At each point of change: commissioner/provider split; productive community, transforming community services, going for foundation trust status, the focus moved away from the community matron service.

As part of successfully integrating the need to have strong professional links is a common theme in the findings and these are presented next.

6.27 Relationships between health care professionals

It may seem very obvious to consider relationships with other health care professionals. Building up a network of relationships with other health care professionals is an integral part of the role of community matron. The impact of the role does not solely rest with what the community matron can achieve; it requires commitment and work from other health care professionals too. So, the strength of relationships with other health care professionals is noted as important by the matrons as evidenced through semi structured interviews and audio diaries. The relationships commented on involve: GPs, DNs, specialist nurses, secondary care staff, mental health colleagues, social services, pharmacists, occupational therapists (OTs), physiotherapists, dieticians and consultants. A dichotomy is apparent. Some report positive relationships; others report difficult relationships. These vary from individual to individual and area to area. Personality characteristics are also noted as a factor in making and maintaining effective relationships:

*‘I think you have to be persistent and I think as well if people realise that you are persistent and you do care...then you can break down that barrier and open up you know...the lines of communication...but it does depend on the person and the agency...’
(Joy: community matron, area 1, p8:364-366)*

That effective relationships between HCPs may be expected to be a ‘given’ is highlighted as being far from reality. Such persistence takes time which is hard to record and impacts on the matron as an individual, which is an aspect which will be explored further under the future theme of invisibility.

In order to make the patient journey seamless, community matrons work on relationships with staff on the wards where their patients are admitted. This has varying effects. In area 1, Isobel illustrates the point by stating:

‘I tend to go and visit my patients if they’re in hospital...and just jot in the notes that I’ve been there, leave my contact details, planning the discharge, make sure that you know they’re aware that they’ve got a matron so that they can let me know when they’re coming out so..... I know some of the names of the staff and things, so when I go on they oh hi matron...’ (Isobel: community matron, area 1, p10:510-513)

However, another community matron in area 1 reports very differently on similar actions she has taken in an attempt to build relationships with staff in the acute hospital:

'but if you go and turn up on the ward, you're not always gratefully received..I will write in the notes ...I'll leave leaflets' (Lauren: community matron, area 1, p13:636-638)

Breaking down the barriers with local hospitals is not a key area for community matrons in areas 2 and 3. However, the managers in area 3 point to improved communication and relationships as a result of the merger of community trust with acute provider. However this improved communication is as a result of hard work around terminology and language; the need to find a common language:

'We had to use that language for people to understand what we are doing. Language has been a big learning curve for me because we used to go in explaining what we do in community language which we have really changed now we have gone into the acute & we talk about outreach, HRGs (health related groups) as well and short stays'. (Rachel : manager, area 3, p6:219-222)

Maintaining good relationships appears to be built on the ability to communicate effectively with other parties through a partnership approach. Although most of the community matrons who participated in this study were independent prescribers there were occasions when a partnership approach was taken to ensure optimal care:

'spoke with the GP...we reviewed the medication and he agreed to increase a dose of a betablocker... I am a nurse prescriber ...independent prescriber but the complexities of patients situations when there's so much going on ... my knowledge is really useful and sort of helps me have a conversation with the doctor really but as in this instance ...it's far better to go and speak with the doctor and agree a management plan together rather than me initiating a change in prescription.' (Veronica: community matron, area 1, audio diary p9:389-393)

This can partly be seen as a learning process, but also may be used as a way of improving GP confidence in the matron's knowledge and ability. Although generally relationships with GPs are noted as good, there are exceptions as reported by Liane, community matron in area 2:

'there's a real lack of involvement with a lot of GPs I'm finding, there are a couple that are very good and then there are others that don't engage with you at all.' (Liane: community matron, area 2, p9:297-298)

As a means of improving relationships, community matrons exhibit creativity to bring about change. An excellent example of an innovative approach comes as the result of an organisational means of using protected learning time. This brings health care professionals (in area 1) together for a lunchtime meeting where various speakers talk about updates to services, and new innovations:

'Joy: lack of contact with two .but what I've found is we had a Protected Learning Time event last week ...and I've mentioned a particular GP to my manager...just saying...I'm not getting any referrals..I'm not getting any feedback about patients...that I'm writing to him about...so what I did was ...at the Protected Learning Time..we have lunch provided..and he was al...he was there at the table having lunch and I went and sat next to him... and I was off yesterday and I had a referral yesterday...so... yeah, that was quite a strategic move on my part so I just ...

Researcher: so you had a good chat to him

Joy: not just about work ..about other things as well...even TV..that programme he'd seen the night before that we were discussing and so I just happened to say..oh do you have any new patients for me at the moment? And a Practice Nurse was there as well, so I left my group from here and went..I'm just going to go and sit with this particular doctor and so I'm trying to make some inroads. I don't know whether the practice nurse nudged the GP afterwards or whether he thought oh..I've got this patient ' (Joy: community matron, area 1,p4:152-182)

Difficulties with relationships cross all professional divides and there are examples where communication is not a 2 way process. Lauren describes her frustrations when specialist teams involved with her patients, do not let her know about changes in care:

'I think that's the hardest part of ..especially I'd say other specialist teams in the community don't ...we don't communicate very well with each other and that's the hardest part of organising a complex care package cos you ask someone to go and do something but they don't tell you what they've done...you would expect a reply as a professional courtesy really...and more having a trust and ...having that relationship ..' (Lauren community matron, area 1, p4:173-175)

Relationships with health care professionals were also presented by community matron participants in relation to joint visits.

6.28 Joint Visits

In audio diaries and in interviews community matrons mentioned undertaking joint visits with other health care professionals. This was seen as beneficial on 3 levels: in order to support the community matron, in order to provide the best care for patients in particularly complex situations and to act as a learning tool. It was also felt that communication and relationships were enhanced as a result of this model of working. Although seen to be a model offering many benefits it was a tool that was used sparingly and when need necessitated acknowledging the workload of all parties involved.

This is illustrated by Ellen, area 2, who states:

'with the specialist nurses and that helps us manage the patients they, because they've got, we've got the generic knowledge but they've got the specialist knowledge so we

feed into them when we're really stuck with certain things,' (Ellen: community matron, area 2, p3:77-80)

Conversely, Sophie, a GP in area 3 considered that there was not enough utilisation of joint visits with her and her colleagues:

'things like there were two patients earlier in the week that they had asked us to go because they had swollen legs...neither of them was particularly important and actually we didn't manage to get the VW there at the same time, but if we had done it would be much more useful to have that dialogue and say this is why I am not worried or this is why I am worried and this is what we are going to do' (Sophie : GP, area 3, p1:30-35)

This is partly in response to changes in skill mix which had occurred in area 3 as a result of the implementation of the virtual ward. The implication was that had the community matron seen these patients, then the GP would never have been asked to visit. In an attempt to build confidence in less experienced staff, the GPs offered the opportunity to go on joint visits as a learning opportunity.

Having presented findings which link to the idea of integration, I now offer findings associated with commissioning and the changes to Clinical Commissioning Groups (CCGs) which also report a desire to improve the integrated nature of services to improve the management and care of individuals with long-term conditions.

6.29 Changes to commissioning

Fundamental changes were noted by commissioners, managers and GPs in relation to commissioning of services as a result of the introduction of clinical commissioning groups (CCG) (DH 2010a, Great Britain Parliament 2012). Findings showed a consensus amongst these participants about the continuing need for a community matron role, but generally based around integration:

'I certainly think, in terms of the GPs I have worked with in the commissioning support until which I am now in, working with GP commissioners they're all desperate to promote better integration, but they feel there is a long way to go in terms of achieving the model I described & I think they are right, there is a long way to go and it sounds easy enough, one can describe it quite simply, but to achieve that in practice operationally is quite difficult and there is a lot they want to see changed, so I think they totally support the integration agenda & support things to move faster than they have in the past.' (Rita: commissioner, area 3, p3:110-116)

One manager noted that changes to the organisation and operating of the community matron service had been very important:

'I think if we had kept the status quo, I don't think we would still have had the community matrons.' (Rachel : manager, area 3, p3:98-99)

A GP on a clinical commissioning group took a broad view:

'Well, I suppose the fundamental question will be will we want to commission in its current form or do we want more matrons or fewer. I think most GPs like matrons to be practice attached and certainly I like that model rather than the geographical model. I think matrons are valuable.' (James: GP, area 2, p2:49-52)

With such a major change in the way services are commissioned, new members of Clinical Commissioning Groups offered insight into the challenges as they saw them. As aspects they discussed linked to possible effects on them as individuals I felt this was a good fit for the person theme. It should be noted that they often talked about decisions in general rather than about the community matron role and service.

In terms of responsibility for commissioning all the GPs expressed their interest in the area, noting a desire to make a difference to patients. There was an acknowledgement that many of their colleagues were concerned about their new role in commissioning as noted by Sophie:

'Horried though some are mad keen' (Sophie: GP, area 3, p1:17-18)

Despite the overall positivity in their new roles, there was a dichotomy in individual GP viewpoints. One GP talked of a personal cost to undertaking commissioning (area 2), and yet wanted to undertake the role in order to:

'to make things better for patients' (James: GP, area 2, p1:9)

whilst another expressed a sense of personal development and increasing leadership skills as a result of the process to date, yet expressed anxieties about the ability to act as *'patient advocate and to hold the purse strings'* (Lyn, area 3) and also that:

'I do feel it's a bit of a poison chalice' (Lyn: GP, area 3, p3:100-101)

This comment related to previous practice where, for example, if a patient could not get a drug because it wasn't funded, GPs were able to lay the blame elsewhere. Now the decision not to fund a drug would be because of GP decisions. The result was that this GP was trying to be positive and yet ultimately felt worried. The third GP (area 3) wondered how GPs would be able to exert pressure over large PFI (privately funded

initiative) hospitals.

As a part of these views, two of the GPs had clear visions of what they wished to achieve in the new roles, both in relation to patients with long-term conditions and current community matron service provision. For Lyn the virtual ward model seemed set to continue, encompassing the community matron role (Sophie concurred on this point) with additional skill mix and extended working hours and the potential for increased monitoring of patients with complex long-term conditions within the community. James worked in an area with autonomous community matrons, but issues with capacity on caseloads and delays in response to referrals had led him to debate the possible merits of skill mix as well.

Next, I present findings which link to the delivery of health care by community matrons as seen by all participants. Sub themes include health promotion, communication, medication, leadership and management, telehealth and end of life care.

6.3 'A little bit of extra effort': delivery of healthcare by community matrons

6.31 Health promotion

Although health promotion for the individuals they were case managing was seen as important in the role, community matrons expressed varying degrees of confidence in undertaking this facet. It often depended on the professional background from which they came. Two matrons, from different areas but who had an acute background expressed similar views in relation to the control available in hospital around diet. This is illustrated by Trish (area 1):

'I found what the difference between the hospital setting and the community setting is whereas in the hospital setting you can quite enforce a lot of things like the patient's diet while they're in there...healthy diet ...basically what's provided by the canteen and the restaurant...but when you're out in the community although you're promoting health promotion...it is always still the patient's choice...and you can say as much as you like...you can give all the recommendations'...(Trish: community matron, area 1, p6:289-293)

Conversely, Isobel, a community matron in area 1 was a former practice nurse and her outlook on health promotion was much more relaxed and she notes:

*‘that’s my favourite bit though...I love that ...cos as a practice nurse that’s what you did’
(Isobel: community matron, area 1, p9:459)*

The contrast between the views of Trish and Isobel suggest that community matrons are not systematically trained for this work but rather take to it according to their personal preferences and background.

There were cultural barriers to health promotion too which community matrons needed to be aware of and to work sensitively to overcome. Knowledge about the individual and their cultural background was necessary. This is illustrated by Kate’s observation:

‘and the Asian population as well it’s things like weight loss because obviously a lot of the women are overweight and with the diabetes and you know...renal failure and things and it’s trying to educate them to lose weight but it’s ..that again it’s really difficult because in their culture being overweight is seen as a really good healthy thing because they’ve obviously got some wealth’ (Kate: community matron, area 1, p10: 502-505)

Despite some reticence on the part of community matrons about how health promotion advice would be received, patients have an expectation that they will be on ‘the receiving end’. One patient, Harry, stated that his community matron was the first health care professional who had taken time to explain *how* he could stop smoking rather than just telling him he needed to. I consider that this shows an understanding of Harry as a person. He proudly told me that he had reduced his cigarette consumption from 60 a day to 10. In addition he had gone to considerable lengths to alter his diet:

‘I mean I’ve stopped now and I’ve given up all fried stuff...everything I have now is either steamed or boiled where before I didn’t...Lauren told me that...then I do exactly what she tells me to do...and it does help me like...you know what I mean?.’ (Harry: patient, area 1, p5:135-137)

Consideration of the person’s needs in relation to health promotion is exhibited as part of this facet of care delivery. Now findings are reported in relation to communication.

6.32 Communication

Communication links with many aspects of what has been described previously and what is yet to come. There is a clear association between care coordination and communication. Presented here are examples of where community matrons and patients and carers think that communication has impacted on care, or has an impact on them as individuals. As Kate illustrates, having good communication links, which work

both ways can and do help to keep everyone abreast of developments in individuals' care:

'and I think actually going back to that man in hospital I had three phone calls that day from I think it was the ward, from his daughter and from the social worker funnily enough erm...they all rang me to say that he'd been admitted, so I thought that's brilliant ...that's worked (laughs) don't know how the social worker knew to call me (laughs)' (Kate: community matron, area 1, p8:364-367)

With the complex cases which many of the individuals who are case managed present, Veronica notes the impact on herself from communication:

'difficult in on a number of fronts...the subject ...the stuff you're talking about can be more sensitive and more emotionally demanding ... the different people you're having to communicate with ...I don't know if...it's harder...but more ...on a more frequent basis...you'll be communicating with a whole range of people from consultants their secretaries...a lot of message leaving to try to get to people you need to communicate with...' (Veronica: community matron, area 3, p3: 101-105)

The ability to make the role of community matron work can be influenced by effective communication. The following example, offered by Lauren shows how she uses her knowledge of one of the patients on her caseload to make a direct difference to that individual. Direct communication with the consultant via the patient delivering a letter enables the consultant to be presented with additional facts, which the patient lacks confidence or ability to deliver verbally:

'because I see him ...he only goes to the hospital every couple of weeks but he deteriorates very quickly so ...from my assessment if I've gone in and I've been very worried about him some days, he's been going to the hospital and the next day I've given him a letter to take with him...say right we need an xray, we need bloods..can you get back to me and the consultant always does either email me or phone me back if it's urgent or kept him in and drained it, so...and I've had letters back saying thank you very much you know..you've excellent clinical skills...' (Lauren: community matron, area 1, p4:189-200)

Part of the personal biography of a patient could be considered to be their home environment. As such community matrons and any HCP working in the community have many additional knowledge strands to employ which impact on the health need and care can be planned accordingly. There is also acknowledgement of communication with patients and carers as part of a partnership approach in effective management and that this can follow from communication:

'cos communication is very important I mean we all know that if..when there's a breakdown in communication things don't get done or things are missed... or people are put at risk and so it is important that you have that two way communication and also that you more importantly that you're keeping the patient and the carers in the loop of what's going on and they're part and parcel of your management plan' (Natasha: community matron, area 1, p5: 231-236)

This inclusion in conversations, planning and feedback, as Natasha suggests, is welcomed by patients and carers:

'but what makes the community matron different she communicate between me and the doctor, she can communicate between me and the hospital..the same as my wife...when I let her come from the hospital ..we do not understand what it mean, what it term of it...she explain us' (Paul : patient, area 1, p2:56-59)

Having conducted this interview with Paul, he presented as a quiet and reserved man. As part of that he said very little, but in saying little, he actually had very clear and strong views about how the community matron had helped both him and his wife. The increased level of communication that the community matron afforded them had made a difference to both.

Another area of care delivery which appeared frequently in participants' transcripts was issues associated with medication. I have considered this aspect next.

6.33 Medication

As noted elsewhere, there is overlap when considering various aspects of care. I consider that this is the case between medication and self-management and independence. As per the definition set out in the appendix 9, I concentrate on patients' understanding of medication issues, along with actions employed by matrons to improve concordance. Prescribing issues are also presented.

The audio diaries recorded by community matrons are littered with accounts of patients getting in a muddle with their medication. The obvious and seemingly popular resolution is to have medication in a blister pack/dosset box. A couple of examples illustrate this issue:

'I found that a patient was struggling with his medication. Spoken to the GP who will now put the patient on the blister pack to make things easy for him' (Trish: community matron, area 1 audio diary, day 6 entry 3)

Although Trish's example is relatively straightforward, Olivia's discovery that a husband had inadvertently been giving his own medication to his wife was potentially very

serious. This had partly arisen because neither the husband nor wife could read English. The community matron's innovative solution was to organise blister packs from different chemists so there was a clear demarcation around the chemist logo for husband and wife:

'Husband and wife have their dosset system dispensed from separate chemists so therefore preventing any errors' (Olivia: community matron, area 1, audio diary p4:154-155)

Patients and carers report how useful blister packs are. For Nina (carer area 3) whose husband Arthur had a tendency to get a bit muddled with his medication, it had allowed him some independence:

'Nina: but it's better now because he doesn't get mixed up and he doesn't like me to do it, so I'd come out the way, but he would be doing it wrong sometimes.'

Researcher: So it's brought back some independence?

Nina: Yes that's right' (Nina: carer, area 3, p3:77-80)

A seemingly simple system did create some problems if patients were hospitalised. Often this would result in them being discharged without a blister pack. As Kate records:

'I sorted out her medication because she used to have blister packs prior to going into hospital and then was discharged, the blister packs had stopped and she had carrier bags full of medication so we've got the blister packs recommenced, and they will be going in in a couple of days time' (Kate: community matron, area 3, audio diary p2:49-51)

An issue related to discharge without blister packs can mean that care agency staff won't administer medication, because it is not packaged in a way that they are allowed to do so. Lauren reports liaising with the hospital to organise the blister pack on discharge was well received by the acute sector nurse:

'actually thanked me for phoning and said pharmacy can get that made up no problem...so again so just a little bit of extra effort ...little bit of communication and a lot of stress and hassle can be sorted out very quickly'...(Lauren: community matron, area 1, audio diary p2:57-60)

Although this may be considered part of the role, the community matron clearly has a grasp of issues here and puts in the time and effort to alleviate difficulties for the patient on discharge before they happen. This could be considered a system error. As the community matron shows awareness of this 'gap' she 'plugs the gap' arguably making it appear as though everything works well, because it is not recorded or seen. This is in line

with Liaschenko's statements around boundary work. By undertaking this task and sorting out the issue, the community matron may be working outside her remit at a personal cost because it makes her busier. As no problem has arisen due to the community matron taking a proactive action, this action may not be recorded or seen and as such is invisible. Yet such an action could be seen as very influential in maintaining this particular patient at home.

The ability to prescribe independently is welcomed by community matrons and patients and carers. Kate, a community matron who had undertaken a course on independent prescribing whilst in the role states that the difference between 'then', when she had to see the GP to organise changes to medication and 'now' where she is able to make her own decisions ensures that the process is more efficient:

'you know the more lean approach...so you haven't got to go to the GPs and then come back and then get the prescription and you know...it's such a hassle' (Kate: community matron, area 3, p1:23-25)

A community matron in area 3 who was in a similar position to Kate in terms of ability to prescribe put a positive spin on having to liaise with the GPs which she considered helped her to cement her relationship with them whilst new in post:

'the GPs don't know me and I've not really got any history with them, so in terms of not being able to prescribe it's actually been a good way of relationship building that I tend to say I think it might be worth trying XY and Z, so I'm trying to sort of think for myself knowing that I'm going to have to do it quite soon. But by me suggesting to them I think that they are getting a respect that I do know what I talking about.' (Sally: community matron, area 3, p1:35-39)

However, from a GP perspective, some concerns were raised about prescribing. This was in relation to skill mix in the virtual ward model rather than community matrons *per se*:

'I think another concern amongst doctors generally, not necessarily all doctors, but is the level of competence of some of the VW staff and whether or not... can they deal with heart failure, are they effectively trained enough to recognise subtle things, so there are some doctors who have issues and concerns about that particularly with prescribing. It's not a concern that I have particularly got. I've not felt that on the whole it has been inappropriate, but I think hypothetically that may be an issue.' (Lyn: GP, area 3, p2:43-50)

Such concerns about prescribing, by GPs, have the potential to undermine community matrons and their ability to embed the role.

An audio diary entry from an area 3 community matron highlights the difficulties and complexities associated with retaining staff which could impact on the comment by GP Lyn:

'it is a new role to them and they need a lot of advice & support as obviously the pts we go to are quite complex & unstable, so you do need health assessment & prescribing which again these are skills which are lacking & need developing in our staff.' (Liz: community matron, area 3, audio diary entry 45)

Patients and carers appreciated the timeliness of being able to access quicker prescriptions via their community matron. One carer reports:

'and in no time the prescription was here you know and in the space of two days mum was cleared up' (Dolores: carer, area 1, p4:135-136)

There is evidence that community matrons invest a lot of time in explaining both health conditions and medication regimes to the patients in their care. How much patients choose to take in is variable. In area 3, Arthur takes his medication on trust, whilst when I interviewed Rory he insisted on me fetching his medication from the cupboard and he took 20 minutes going through each item with me and explaining, very accurately, what they were for and when he took them!

Having presented the findings surrounding medication I now present issues associated with leadership and management in relation to the community matron role, but also in relation to care delivery as a result of changes to the service delivery models.

6.34 Leadership and management

A particular change commented on by managers (Miranda, Rachel and Ruth) in relation to questioning in their interviews (see appendix 8 for questions) was around management and leadership by community matrons. Some of these issues were felt to have been exaggerated by the ineffective operational plan (Jane). Changes in service design in the other areas had increased the role of clinical leadership undertaken by community matrons (Miranda, Rachel and Ruth).

Professional practice and leadership were linked in the domains of case management. Data from the parent project found that some community matrons in area 1 struggled to see themselves as leaders and many linked leadership with leading a team. As they were

autonomous practitioners and did not have a team, they often found this a confusing question. It also displayed confusion between leadership and management. However, it was these individuals who did not take up my request to re consent to their data being re-used. The leadership role by community matrons in area 1 was noted as problematic by their manager also and dependent on individual skills rather than the role. For some matrons, leadership was best described in terms of care coordination:

'From a leadership point of view here and the coordination point of view, I think the two sit well together and I think yes in that instance I did lead.' (Veronica: community matron, area 1, p10: 461-463)

Perhaps the issue is more of difficulty with defining leadership. Natasha states:

'leadership is key in this role..I don't think if you ...are not able to lead I think it would be an extremely difficult role to fulfil in every sense of the word...and you...and not only just leading in terms of coordinating but you've got to be actually be prepared to put your foot out sometimes in areas where people might think well I don't think we've done this before so I don't think we can try it...and you'll have to say well I'll ...I'll do it first so let's see how we go with that whole area.' (Natasha: community matron, area 1, p9: 398-402)

Throughout the audio diaries and interviews there was obvious leadership shown. Often this was demonstrated by thinking and problem solving 'outside the box'. Although largely in relation to care coordination, for some this also manifested in leading other community matrons to make changes in the way they worked to improve their visibility within the role.

In exploring the data offered in area 2, the issues around leadership and management were equally confused and seemed borne out of service re-design. The term 'clinical leadership' has become part and parcel of the community matron role in 2012 in both areas 2 and 3. This is supposed to offer a clear distinction, but this is one community matrons attempt to explain:

'Liane: the idea is that the community matrons are very much the clinical leaders and supervisors but what we've got beneath us is a team manager who is purely management.'

Researcher: Right and nurse?

Liane: She's a nurse yes, you've got your district nurses you've got district nurse band 6 who's supposed to be the sister for the team, you've then got a band 7 manager and then you've got band 8 community matrons as clinical leaders and actually that doesn't work very well at all. I think what we need is a band 7 clinical team lead person.'

Well I'm not sure whether you need two levels of band 7 because it's very difficult for us, there's management decisions being made and we're not being involved in them yet we're being expected to lead teams, and what we're finding is if somebody doesn't know what to do it's very much the matrons will pick that up, they're the clinical lead, and then they're talking about us being involved with the whole integrated team but they have their own managers so it's not a very clear sort of structure or hierarchy really, and I think the teams don't know who to go to, do they go to their manager or do they come to us, what are the differences and we've tried to sort of narrow those you know work those out bits it's still a bit difficult.

It's causing a lot of conflict.' (Liane: community matron, area 2, p3:91-109)

The conflict partly comes from role blurring and district nursing sisters seeing their role within their teams as clinical leadership. As noted previously, such changes do not allow roles to embed and new roles to be accepted. Ellen illustrates how she has tried to 'smooth' contentions with the following explanation to DN colleagues:

'What we've said to the district sisters when the district sisters found out we were going to be the clinical leads for the team, they were a bit like oh where's our role, but we've made it very clear to them no the management side of it is yours, but we will deal with any clinical problems that you've got and any support you need clinically.' (Ellen: community matron, area 2, p6: 190-193)

The ability to offer clinical leadership has been further compromised for Ellen and her colleague who have been moved away from the team to whom they offer clinical leadership and now work out of a separate building two miles away. The ability to listen in and hear what is going on has been lost and so the ability to actively assist with clinical issues has lost spontaneity. Now they have to wait to be consulted on issues, thus allowing the district nurses to maintain the status quo. In area 2, community matrons had been re-banded 8A and as a result of this advanced level were expected to know about and advise on quality issues, governance arrangements, offer guidance and report gaps and issues with service provision all of which were said to be clinical leadership and not management, as stated by their manager.

In area 3, frustrations run quite deep about changes in the service delivery model and the impact this has had on the community matron role. For an autonomous community matron in area 3, comments are strongly linked to those of some matrons in area 1 around leadership and managing care:

'I would say the leader of the management of the care of this person, so in bringing everyone in and getting everyone to work together and knowing what the goals are for

this patient then yes definitely, bringing people in appropriately, using them appropriately, explaining to them and the patient quite what the focus is of this intervention be it short or a longer turn so yes definitely trying to be the, well the coordinator and the case manager of all the different aspects in this persons care' (Sally: community matron, area 3, p8: 294-300)

However, for some community matrons who had been in the role, almost from the beginning, feelings were very different. Lucy had been asked to be part of the virtual ward pilot. This was her reflection on where she felt clinical leadership had been lost to man management:

'But after working like that for I think it was 3-6 months I just didn't like it because it involved man management as well because you've got a team of people that's the real reason that I didn't want to go into management that's why I went to be a community matron in order to stay clinical with the patients so I thought no'. (Lucy: community matron, area 3, p3:95-98)

Prior to becoming a part of the virtual ward, Liz saw her leadership skills around leading the coordination of care in relation to patients need. There is a degree of disillusion in both her interview and audio diary:

'At the moment we are very much managers because it's part of the virtual ward'(Liz: community matron, area 3, p1:36)

'Frustrations I think today is a lot of my job today and most days is that my job is not clinical anymore. I spent an awful lot of time doing things like delegating visits, e mails, handing over pts, dealing with complaints.' (Liz: community matron, area 3, audio diary entry 36)

'As you can see most of my time is taken up with managerial things and I would say a vast majority of my role is and I would say this is detrimental. I have been trained at a high level and I think that 80-90% of my time should be spent with clients and that is the value of my training and that is where it should be put.' (Liz: community matron, area 3, audio diary entry 53)

Even the community matron who was instrumental in the pilot of the VW concedes changes to her role as a result:

'On the virtual ward I do less clinical I have to say because I'm managing a team now and I only had myself to manage before so all my work was clinical I'm clinical from the perspective that everybody comes back and discusses the visits with me or they ring me while they're at the visit to say I've found this what should I do about that, so I'm clinical I'm a clinical resource all day when I'm on duty,' (Chris: community matron, area 3, p7:269-275)

A certain element of justifying as a means of showing that clinical impact remains:

*‘I’m on about management I’m really on about patient and virtual ward management ‘
(Chris: community matron, area 3, p7:285-286)*

So this can perhaps be seen as the same role as ward manager in a hospital setting, where much of the role is that of management rather than a clinical focus. Despite this justification, many of the audio diary entries describe management and HR issues as well as attendance at meetings. One manager was very clear that community matrons were not in post to operationally manage, but the perception of another manager was that community matrons managed virtual wards. Through the interviews, managers gave a hearty defence that issues such as teams meetings, liaison, management plans, rostering of staff and organising discharges were all aspects of clinical leadership and not management that would keep the community matron away from direct patient care. As noted this was not the perception of many community matrons.

Delivery of care has changed in some areas as a result of changes to service delivery models and therefore changes to role. Embedding of the role is also affected. Leadership and management aspects of the role are debated, but erosion of the advanced skills of the original community matrons can be seen from patient facing to managerial tasks. This has an emotional impact on individual community matrons. As will be reported in section 6.62, these changes do not appear to adversely affect the patient and carer experience.

Another area of healthcare delivery which was mentioned by some community matrons was the introduction of telehealth as a means of managing individuals with long-term conditions.

6.35 Telehealth

Telehealth has been introduced as a means of monitoring vital signs which patients do themselves and then relay them to a healthcare professional. It had brief mention by participants and only those participants in area 2 and 3. One GP seemed frustrated by the system (which he wrongly names, so perhaps being another example of a new innovation being implemented without proper engagement of clinical staff):

‘this tele medicine stuff, which was a bit of a pain to be honest because we’d get a phone call saying somebody’s SATs were down can you go and see them and a lot of the time their SATs were always down’ (Sophie: GP, area 3, p2:50-52)

What is not clear from this quote is who was asking the GP to visit. Again this is in an area where the virtual ward was in operation so it may be possible to conclude that it was another issue linked to change in skill mix and thus levels of experience. In area 2, Liane reports a lack of interest from patients as the project is rolled out:

'I've found it, I've found it very difficult to actually really actively engage people to participate.' (Liane: community matron, area 2, p6:218-219)

How and why patients are not keen to engage would be interesting to know in order to try and make the system more useful as has been seen across the UK. Liane goes on to record in her audio diary, that the roll out has had a positive impact on her workload thus offering the potential for increased capacity:

'from my point of view, telehealth has reduced the number of visits I need to make to these patients, but I am not convinced that it has resulted in less admissions to hospital.' (Liane: community matron, area 2, audio diary p4:146-147)

Having expressed finding in relation to telehealth, the findings around end of life are now presented.

6.36 End of Life Care

As end of life was one of the domains in relation to the role of community matron this question was asked to all community matron participants. Managers also had useful insights into this major area of care. Two clear themes emerged. One surrounded the poorer options available to individuals who approached end of life as the result of an organ failure long-term condition rather than cancer. This was commonly expressed in relation to disease trajectory which was 'easier' to predict in cancer patients. The other was linked to the myriad of services available to support with end of life. Commonly, the community matron continued to coordinate as they had a relationship with the individual and family but the district nursing service would provide care. This could be dependent on the background of the community matron. Those who came from a DN background often found this area easier to manage.

Hospitalisation was noted as common in the group of patients with organ failure, but in area 2 a lot of work had been undertaken with non-cancer patients to try and change the outcome:

'So what we're looking for is giving these group of patients the same service that cancer patients have had for quite some time and the beauty of this paperwork is that we can fax the out of hours so that it's on a system now that a patient has a preferred quality for care, that they have an activated DNAR and that if ever in the middle of the night which always happens at 2 o'clock in the morning, patient can't breathe, the family panic, they dial 999, it's comes up as an alert, this patient has advance COPD, is end stage, wants to be cared for at home, is known to DNs community matron, DNAR in place, they respond, they do whatever they could to make the person comfortable, liaise with the district nurses if need be but ultimately the patient isn't whizzed off to the hospital when it was against their wishes.' (Anna: community matron, area 2, p8: 314-323)

The distinction between actual end of life and the palliative period when supportive care was still actively required was also mentioned by many matrons. Liane felt very strongly about the need for active care to manage symptoms, even at a late stage, because poor management at that point often resulted in hospitalisation:

'I think we probably need to be much more involved in palliative care, what I'm finding I think is that district nurses are excellent at terminal care for cancer patients, what I don't think they are very good at is managing that supportive care period in patients with non-cancer conditions, I think that there is a really a lack of managing these patients properly. But it's very difficult because once somebody's targeted as palliative or labelled as palliative well they should be under the palliative care teams or under the district nurses and I think for your end stage heart failure COPD, they don't actually fit because they still have symptom control issues, they still need their diuretics adjusting, their medication adjusted they still have and exacerbations, alongside needing maybe ---- oxygen, palliative care intervention so I think we need to be picking up a lot more of these patients' (Liane: community matron, area 2, p 9:314-320)

This insight comes from the knowledge and experience of this community matron's previous role as a heart failure specialist nurse and shows how beneficial different viewpoints can be in the care of patients with long-term conditions.

Changes in service delivery had made a difference to end of life care in area 3. Initially the VW had not offered end of life care, but a change had meant they now did in order to maintain continuity for patients and carer. This was an exception to the rule of discharging individuals. As Rachel, a manager in area 3 notes there were a lot of debates about this policy:

'It did give us a good opportunity to challenge our clinicians and also challenge the commissioners' ideas around how this should be working, because they thought EOL should be passed on.' (Rachel : manager, area 3, p5: 168-170)

End of life care was seen by the district nursing service as their domain and so introduction of the community matron role meant that there had to be effective

communication in order that patients received the best care at end of life. This was an example of protecting roles on occasions:

‘End of Life Care which is where I had my problem with my DNs, I think depending on who else is involved,’ (Megan: community matron, area 1, p15: 728-729)

However, communication, breaking down barriers and general persistence paid off in resolving differences.

This theme has reported findings from the study participants which have considered aspects of health care delivery by community matrons. Next I present findings associated with psychosocial aspects of living with an LTC and working with individuals with LTCs.

6.4 ‘Climbing Mount Everest’: psychosocial aspects of living with a LTC

Within this sub theme, findings are presented in relation to support, as perceived by patients and carers; mental wellbeing as defined in appendix 9, non-adjustment in relation to living with an LTC and advocacy where community matrons work to try and resolve issues which matter to patients and carers.

6.41 Support

Predominantly patients and carers expressed positive views of being on CM or VW caseloads and these views appeared to come from the strong relationships and levels of trust which had been established, sometimes within a relatively short space of time. Such comments include:

‘I trust her with my life’ (Harry: patient, area 1, p9: 136)

‘She’s the best thing that has ever happened to us’ (Pam: patient, area 1, p2:66)

and later is qualified in relation to the difficulties of getting older and sicker:

‘when you’re younger you’ve got the energy to go and walk around and fight for what you need but you just sort of give up and stop in the background like’ (Pam: patient, area 1, p3:82-84)

‘when you have confidence in someone it’s like a medicine’ (Paul: patient, area 1, p2:49)

The majority of patients and their carers who participated in the study held their community matron in high regard. This may be expected because of the selection

process and was discussed in study limitations (section 5.8). A GP participant also commented on the high regard that patients on her list had for the community matron:

'I think that they feel that the level of monitoring and level of being examined and kind of looked at by the CM makes them feel as though they have had a really thorough MOT. Those are words that I have had from them: 'they've given me a good going over doc' (Lyn: GP, area 3, p1: 10-12)

However one patient interviewee could be considered counter case and was not effusive when considering the CM and stated:

'she is useful, I suppose' (Ava: patient, area 2, p4:112)

Carers also expressed a sense of relief and safety that a named and contactable service was available to support them, which in turn helped to reduce their stress levels:

'makes it much easier for me..easier for carers' (Edie: carer, area 1, p3:88-89)

'somebody there...be reassured.' (Edie: carer, area 1, p4: 121-122)

'she always includes me in the visit...how I'm managing and all that' (Dolores: carer, area 1, p1:26-27)

A value was placed on ease of contact and timely replies and was noted across all geographical areas. Patrick and April make a distinction about timeliness of the community matron versus the GP:

'Patrick: I'd ring her up. I'd ring S. Because to get to see a doctor it's a big hullaballoo, you know what I mean.

April: It's about a week waiting.

Patrick: That's the worst part but with S she'll come right out' (Patrick and April: patient and carer, area 3, p2:38-40)

As Patrick's community matron works alone getting to Patrick in a timely manner often means re-arranging other visits or getting off duty late. This is hidden work and the cost is borne by the community matron with patients seeing a service which works efficiently and effectively for them.

The time to ask questions, which in turn provided greater reassurance, was also mentioned by several patients and carers:

‘and we’re always glad when she’s coming because if there’s any little problem that’s niggling ...you ask her and she will ...sort it out or say well I’ll find out for you...all that kind of thing...’(Edie: carer, area 1, p11: 328-330)

Characteristics in individual staff were mentioned such as honesty, being non-judgemental, being prepared to go the extra mile, and ability to put people at ease, all of which were noted and added to the positive view of the CM/VW. A level of care and comfort was noted; Dolores (carer in area 1) said that a call to the GP would result in her mum being sent to A&E to lie on a trolley, whilst a call to the CM resulted in suggestions to promote comfort and maintain the individual safely in their own home.

Having presented findings associated with support as perceived by patients and carers, the next section explores mental wellbeing.

6.42 Mental wellbeing

Most community matrons stressed their lack of training in supporting patients with cognitive impairment and the ability to manage patients with mental health issues varied across areas. Some community matrons felt better equipped to support patients than did others. The general consensus amongst community matrons was that more training was needed to improve their effectiveness.

Chris contends that although there are a lot of individuals with dementia, provided they have a good carer this rarely poses an issue. For her, the serious difficulties arise when patients have an acute mental health problem, and raised issues related to gaining specialist support for those patients. She reflects:

‘We’ve had quite a few people with acute mental health problems that have occurs while we’ve been looking after them for their long term conditions and to access mental health service quite frankly is a nightmare. ’ (Chris: community matron, area 3, p9: 351-353)

Aside from mental health, there is recognition of mental wellbeing and the importance that it has on physical well-being. This is true for both patients and carers. In area 2, community matron Geri notes:

‘you can actually see their stress reducing and I am sure that, you know, a lot of these long term patients if they hadn’t got these carers who were in good health they would be in hospital so much more, but it is not just about the physical health is it, it is about their mental well-being and all of those and a lot of the carers are suffering with depression all the issues in relation to the fact they are living with somebody who can’t go out, their social life is not the same, their relationship is altered, so if you can do work with them as

well I think that is a important within the therapeutic relationship between both of them.’ (Geri: community matron, area 2, p6:254-261)

As part of the package of support for mental well-being Veronica reflects that simple gestures can be effective to a degree:

‘I think there is the hand holding component, there is somebody there for them if they want to work with you on that level’ (Veronica: community matron, area 1, p8:372-373)

In acknowledging the link between physical and mental health, Lyn, GP in area 3 notes the importance of better integrated care around psychological wellbeing:

‘oh I’m quite interested in doing all that and in improving psychological aspects, getting IAPT involved and having a nice seamless package with psychological services across secondary and primary care for all of those LTCs and so that’s kind of my vision really.’ (Lyn: GP, area 3, p2:64-66)

Within the therapeutic relationship patients spoke of aspects of care associated with promotion of mental well-being in addition to assessment of their physical needs.

Patients identify aspects such as humour as a way of helping them with their mental well-being. As Harry states:

‘having a joke at the same time’ (Harry: patient, area 1, p5:139)

For Mary, a carer, support is a means of easing her anxieties and she notes:

‘I feel at ease knowing they are behind me all the time’ (Mary: carer, area 3, p5:131)

This support, in turn protects mental wellbeing. Dolores recounts the difficulties of arranging respite care for her 97 year old mother as being like:

‘Climbing Mount Everest ‘.....it’s a struggle to get things sorted out and you can ask her and she will step in and help.....it takes the pressure off me.’ (Dolores: carer, area 1, p3:96-98)

Seemingly small things are noted to have a major impact on patients and carers.

Although Dolores comment may appear to imply physical effort, in fact it incorporates psychological aspects of stress and the social side of having support with her mother which enables Dolores herself to live her life. Organising respite care could be seen to be a social care issue, and therefore beyond the boundaries of healthcare, but it appears to be at these boundary areas where a role such as community matron is at its most valuable for patients and carers helping to protect mental well-being. For some patients

poor adaptation and failure to adjust to living with an LTC impacts them as individuals and can impact the work of community matrons. This is reported next.

6.43 Non adjustment

Despite the largely positive examples presented, community matrons do highlight the difficulties of working with individuals who have struggled in their adjustment to living with a LTC. Isobel stresses the importance of empowerment as a means of increasing self-efficacy and coping:

‘but it’s really important to empower them that you know you’re not dying...you’ve got a LTC that needs to be managed and you’re going to manage it’ (Isobel : community matron, area 1, p7:351-353)

Veronica also sees part of her role as helping individuals to accept and adjust to what is happening in their lives:

‘I think it is around that sort of emotional and psychological support and hoping to help people reach an acceptance almost, to understand their priorities are and what they’d like to do.... I suppose we’re helping, but there’s no cure because the chronicity of the illness is still there...’ (Veronica: community matron, area 1, p8:385-387)

However, despite considerable amounts of work undertaken as part of the community matron role there are individuals who find it difficult to change and adjust. Kate notes:

‘..well one lady in particular stands out, but I wouldn’t leave a rescue pack cos every week she’ll happily take it and get through 20 ventolin inhalers a week and things like that....She’s a lady I’ll never stop going into hospital.....she loves the sick role and she loves hospital.’ (Kate : community matron, area 1, p6: 293-296)

One patient, Ava, who I have referred to previously as a counter case differs from other patients who participated. Her quote shows her knowledge of her condition, but she goes on to display what she later describes as ‘clutching at straws’ in her desire to make her situation better, but not in a way that shows adjustment:

‘Well when I was in hospital the medical term used for me lungs was that they are knackered. I keep doing all sorts of things to try & make meself better, but I’m not going to get better. I realise that now. I’ve tried it all. On Thurs I’m going for another session because I’m going for alternative therapies. I’ve already tried acupuncture; it worked for a bit. I went for my first Reike treatment. I went in & I was breathing so heavily because I am a deep breather to get the air in & I’m supposed to be getting therapy to learn how to breathe quietly, so while I’m waiting for the therapy to come from the NHS, I’ve been paying for it & Reike basically he got me breathing ever so quiet. It’s the first time for a long time.’ (Ava: patient, area 2, p2:45-52)

Other areas where community matrons are providing psychosocial support are numerous and are presented in relation to advocacy.

6.44 Advocacy

The majority of data presented here came from community matron audio diaries.

Community matrons highlighted that sometimes the problem as seen by the patient is different than the problem as seen by the health care professional. Working with patients to solve complex social and often housing issues can mean their peace of mind which in turn means that they can move on to address health problems. As Olivia reflects:

'I've also been involved with [the] City Council Housing and Repairs Department on behalf of this family who have had many outstanding repairs for many months ...I was able to ensure that a joint visit between a senior housing officer was to meet me at the house to go through the house listing all the current necessary property repairs from glass broken in doors, locks not working, hand stair rail not fixed,..... I really feel quite strongly that there are many families who although as our Community Matron role ...our priority is for unnecessary admissions to hospital there are lots of social issues and medical issues, but the social issues need to be addressed as far as the patients are concerned because that ...some of the time is their priority need. Once you've addressed some of the social issues you can then move on to their health issues because they don't always see their health issue although I do see them as important, that's not priority in their mind.' (Olivia: community matron, area 1, audio diary p6:239-250)

This is clear evidence of social knowledge and action that is beyond the healthcare boundary *per se*. However, in terms of holistic assessment and consideration of how different factors impact health, this proactive course of action shows the community matron acting as advocate for this family.

Another community matron spoke of a patient who was failing to cope several months after the death of his wife, suffering deteriorating physical and mental health. Working with the gentleman, she instigated a move to warden controlled accommodation. Following this action, the gentleman is noted to be a changed individual, who has been signed off by the mental health services and now sees the community matron on a reduced basis.

Acting as advocate can make the lives of individuals with fragile health better. Reports of other measures which can be termed advocacy include wading through numerous outpatient appointments, liaising to get individuals seen by different teams on one

hospital visit, ensuring bloods for checking warfarin levels (INR) are taken at home weekly, rather than a sick patient having to spend the best part of a day awaiting transport to and from hospital for a blood test. There are examples of community matrons working with patients and families to launch appeals. A potentially simple action shows the care and dedication of the community matron's work is as follows:

'Arrived to see two patients of mine again a Mr and Mrs and upon arrival at the property informed by the gentleman's wife that the gentleman has actually been emergency... taken into hospital via emergency ambulance because he's developed quite severe and sharp back pain... I've rang up the hospital ...he's actually gone into [name] Hospital and he's actually got an aortic aneurysm... which obviously is quite serious so the lady herself is quite upset and distressed. I have arranged for the lady to be taken to the hospital by a voluntary organisation because she's got no means of transport and obviously from where she lives the hospital is actually out of their area and would be extremely costly just so she can go up there.' (Gill: community matron, area 1, audio diary p7: entry 15)

Being proactive and being holistic and understanding the 'bigger picture', the role of the community matron can be seen as key in ensuring that minority ethnic groups have access to appropriate services. In addition to using the interpreting services, other strategies are also employed. This is particularly so for those individuals from minority ethnic groups which are small in number and do not have networks set up as many Asian minority groups do. In particular, issues arise around those who are unable to read or write, and these include numerous 'did not attend' appointments as patients did not know that they had an appointment. Strategies for overcoming such issues included agreeing with appropriate agencies that they would put a cross on the back of an envelope. The patients would then keep the letter with crosses and ring the community matron. She would then go out and, with consent, read and explain. This system appears to work very well. Several individuals and agencies seem able to comply with the request to put a cross on important letters. Another strategy is the use of poly pockets which have letterheads stuck on them. On receipt of letters the patient is able to compare the letterheads and file appropriately until the community matron can visit. Although the actions of the community matrons may be considered policy issues because they deal with failings of other sectors, more importantly I see that such actions come about because the community matron is in a position to know the personal biography of individuals on her caseload, including whether or not they can read or write. Such actions which are undoubtedly proactive may be considered outside the

boundaries of healthcare. One community matron described her role as that of 'professional friend' in these situations.

A final example of advocacy shows the community matron helping a patient to take a stand over a potentially life threatening issue. It was recorded as follows:

'making the services fit the patient I suppose, and that is a battle too you know, the lady that I was on about a few minutes ago wanted to eat but she can't swallow, she was forty two when I met her at forty five she had made her mind up she wanted to eat, speech and language were saying no absolutely not, it's really important when you are forty five and you have got a family to eat, so I pushed and pushed for a video thoroscopy well we got one good swallow, second one was dodgy, third one was a little bit better but she signed a declaration that she knew what the risks, we pointed out all the risks, we made her husband aware of the risks, we made the carers aware of the risks, she eats now probably three or four times a week, it was an obsession to her she wanted to eat every day and we had to go with it, she had to take the risk and I had to facilitate that, I think speech and language and the Dietician thought I was barking mad, I think I thought myself I was but it was really important to her to be able to do that and what I have realised with this lady she has missions and she goes off on a tangent,' (Jess: community matron, area 3, p6:211-222)

When community matrons are prepared to act as advocate and work with patients to achieve potentially high risk goals which matter so much to patients in the context of their lives, it does not seem surprising that community matrons are held in such high regard by patients and their carers.

Having considered psychosocial aspects, findings associated with the patient journey are presented next.

6.5 'A jigsaw of care': patient journey

The aspects presented here include referrals, care coordination, hospital discharge and out of hours, as well as self-management and independence.

6.51 Referrals

Referral to other services was often presented as difficult. Communication with Social Services was highlighted as difficult to manage at times, but other community matrons report better successes. In area 1, case managers were employed whose background was social services. Although this provided advantages because they had a good understanding of benefits available to patients and strong community networks, they were unable to fast track referrals. This was seen as a major disadvantage. In area 3, the

virtual ward was set up with a social worker, as reported by Rita, a commissioner, but the post holder received little support and funding was pulled. Response times and associated difficulties are noted:

'I've not had to try and refer anybody urgently but I know colleagues have tried to sort seek urgent social work support and felt that they didn't receive it...at an appropriate response time' (Veronica: community matron, area 1, p4:190-192)

However, the complexities of social service set up between hospital and community based social work teams also provides difficulties for the community matrons and any patients who are admitted to hospital as Veronica recorded in her audio diary:

'some services are so difficult to work with I mean social care...and health the logistics of this situation with both of them having admissions to hospital when they're in hospital ...there were hospital based Social Worker and yes there's a shared computerised record system but then on discharge after the 28 days period of time there were out to one of the area Social Workers ...the duty teams not properly allocated to a regular Social Worker and with cases being closed so quickly after the review by the area Social Workers it doesn't really help with these particular situations' (Veronica: community matron, area 1, audio diary p5:213-219)

Another issue which can affect the coordination of care and referrals results from agencies having separate assessments and separate notes. This can impede communication, as well as duplicating and using valuable resources:

'The Respiratory Team has their own set of notes, the Dietetic Team will have their own set of notes, the Diabetes Team will have their own set of notes, so nothing is really shared...' (Lauren: community matron, area 1, p 5:255-257)

Rita, commissioner in area 3 emphasises the need for better integration which overcomes some of these issues:

'We are trying, like a lot of areas, to what is in effect, whether you call it a neighbourhood team, a locality team, and integrated team, we are trying to have local groups of clinicians & social care workers where they are trained in NVQ level health & social care, whether they are nurses, physios, OTs, SW all providing care in an area in a way that means there is a single point of access to that care, that there is a single care plan, that there is trusted assessment by the lead clinician' (Rita: commissioner, area 2, p2: 76-80)

She goes on to acknowledge that the vision of what is required is rather more difficult to operationalise.

Some referrals which make a difference to patients and carers, comes from the

community matron's ability to coordinate care with third sector organisations. Natasha highlights an agency which she considers will assist one of her patients:

'I will refer this lady to [name] which a complimentary therapy for the particular Trust and I felt that this lady could actually benefit from some form of back massage or some other therapy that they can actually offer.' (Natasha: community matron, area 1, audio diary entry 3)

Sally also notes the value of being able to refer patients to volunteers, which she considers can be instrumental in keeping them at home during a crisis:

'If you don't know what's sort of voluntary agencies are there or what, even if it's just somebody local from the local community centre or a local church that might do a little bit of home visiting as a volunteer who could get a little bit of shopping in for someone that's housebound to help them over a difficult patch, there's loads of people out there in the community that want to do it and volunteer services, now again you've got to be careful of vulnerable adults and confidentiality in these small little villages and communities that I work in actually knowing who these people are it's fantastic and it makes all the difference, and it really will make the difference between someone staying at home and having an admission' (Sally: community matron, area 3, p12:452-460)

Knowing patients, their backgrounds and needs helps the community matron to make appropriate referrals as this next quote acknowledges:

'my Cantonese lady, managed to get her on an Expert Patient course in Cantonese...it's sort of ...I get ...knowing the local area as well ...finding things out ...keeping your ears open ...you know...that's through the Chinese Centre that I went there and had a look around, found out about this, got her referred' (Lauren: community matron, area 1, p14:688-690)

When questioned further about the impact of this referral on the lady, Lauren reflected that:

'Oh gosh, yeah it helped. She had very severe cardiac problems, was operated on and came home and sat in a chair, because she was scared. Now she is on and off buses...she's come on leaps and bounds.' (Lauren: community matron, area 1, p14:715-717)

Patients who participated also acknowledged the benefits they received from referrals made either for them or their carer. Predominantly for carers it was the space afforded them by some free time that they could use for themselves. Nina explains about the Admiral nurse who came to visit following a referral from the community matron:

'She is going to organise something for us if she can either someone will take Arthur out and I can do what I want or take us both out together. She's going to try and organise that.' (Nina: carer, area 3, p6:159-161)

A referral to the hospice was seen as an action which had helped Patrick and April:

'Patrick: Yes I go to one for the day every 2 weeks and stay for the day. Oh the way they treat you there is lovely

April: So that was through the community matron if you like, so that was quite good for you

Patrick: yes it was. Last time I went they had a bloke come and sing and he volunteered to sing and it was quite good. I like anything like that. About a year ago we had some people from France, a choir of young girls who were singing

Interviewer; And how does that help you April with Patrick going for a day?

April: Well I could go as well but what I do is give myself a day off and like tomorrow I am going to have my hair done and then I shall probably pop into [town] or something, you know, so that gives me a bit of space on my own. Not that we don't get on' (Patrick and April : patient and carer, area 3, p5:127-137)

The ability to refer to other HCPs or to voluntary agencies, helps the community matrons enact their role. Wide knowledge of agencies to refer to helps to meet individual patient needs. Such actions are appreciated by both patients and carers.

Care coordination will now be explored by using examples provided by community matrons. These examples show the complexity, of some patients' lives and also the lengths that community matrons go to sort out holistic needs.

6.52 Care coordination

A lot of the qualitative data collected considered these areas. Indeed for care coordination, 94 references were made from 32 sources. Perhaps, as the ability to coordinate care was a key focus of the role of community matron, this is not surprising. Audio diaries allowed the community matrons flexibility to talk about issues which they felt were hard to document on official systems. A lot of the content was around care coordination. The breadth of coordination which was required to keep individuals with co-morbid long-term conditions in their own homes is illustrated in this quote from Isobel's audio diary (area 1):

'My involvement, just to give you a brief overview from partnership working in particular, with other agencies, would be the increasing her social care package, contact with social services and social worker to also look at her finances, the care agency and the managers, look at the carers and ensuring that her needs were met from a cultural perspective as well as culture respect as well as her beliefs.... Area 1 City Council for the adaptations that she needed to her property.....OT for equipment, working closely with the pharmacy and the GP, regular review of the medication and ensuring the blister

packs were correct and issued appropriately on time.....with the police and the safeguarding team for the alleged assault from my client which resulted in ...her being hospitalised and working with the ward staff...managing her care ...the consultant for guidance about her condition (Isobel: community matron, area 1, audio diary,p1:22-33)

This is just one example of many similar examples across all three areas. Jess in area 3 describes the role as community matron as being the lynch pin:

'but if you can kind of pull services together so we have got the right people in there and working together so that the patients outcome is better, then you have got to be the lynchpin really and I think that's the only person who is going to do it the is the Community Matron, everybody does their part and the all do it very well but they are all looking at their little bit and I think where the Community Matron has the advantage she comes in and looks at everything, she looks at the social, their eating, their elimination the whole lot and pulls all the services together.' (Jess: community matron, area 3, p12:453-459)

Another community matron in area 1 uses the analogy of a jigsaw to describe coordination of care, which highlights that even the smallest role undertaken by other health care professionals can be important in the outcome as a whole:

'I call it the jigsaw of care...because it is a jigsaw to me...everybody's slotting in, one person might have a bigger slot than somebody else but it's just as important as the person who's got you know, a little slot....' (Olivia: community matron, area 1, p3:106-108)

This point illustrates the importance of understanding the roles of others, but it also requires other health care professionals to understand the role of community matron and as explored earlier, this has been difficult to achieve. It would also seem to provide a useful analogy for integration. Services need to work together to provide the best outcomes for patients no matter how big or small their part. Without cohesion, optimum outcomes cannot be met: a jigsaw with a piece missing loses its point and care without an integrated approach loses its impact on the patient's outcome.

Some aspects of care coordination which displays particular examples of impact on the individual, whether that be community matron or patient and carer will be exhibited next. The examples offered are long data quotes. However within the length is the complexity. The first, from Jess, is a situation which impacts the whole family. The family comprises Jess's patient who has had 2 major strokes, he husband and two teenagers. The living accommodation is too small to accommodate downstairs sleeping and toilet facilities for the lady who is doubly incontinent and with permanent menstruation. The

quote gives evidence of communication between HCPs, and voluntary agencies and coordination on a holistic level. The lady in question tries to take her own life:

'My quick fix having just come out of midwifery really by a few years was to get her on the right medication to get her periods sorted.

We put a hospital bed in her conservatory which wasn't brilliantShe rang me one day and said she had had enough she could no longer be a burden to her husband and children, so we got the Crisis team involved, the Crisis Team did a lot of work.

I did a lot of work with her husband about looking for converting the garage to a building that we could have as a shower.....I approached every charity that I could think of and one paid for her patio window to be put into the conservatory....., she is a prime example, she has got an electric wheelchair we know now that she has been into the rehab hospital and had some Botox we have got her walking round the house, the electric wheelchair is for outdoors, we have had the purpose built bathroom with a bedroom.....

and so over a period of seven years we had gone from her being very much a patient to being very independent and she now goes out shopping and helps the carers prepare a meal for her husband, we have had a purpose built building for her to have as a bedroom it was a garage that we converted and to be honest that was a result of her trying to commit suicide'. (Jess: community matron, area 3, p8: 288-322)

The positive outcome demonstrated shows that a significant amount of time was spent on this case. The community matron showed tenacity and vision in order to resolve highly complex issues, with the support of colleagues from different agencies and services. Sometimes the health needs uncovered by the community matron are long standing and highlight individuals with long-term conditions who have slipped through the gaps in the system. Isobel's case shows how she coordinated with wheelchair services and social services to make relatively obvious changes which impact a whole family as well as the individual:

'there is a clinical thing that hadn't been picked up or managed effectively that's ...so for me ...a classic example ...a 38 year old girl with LD, physical disability lovely girl being cared for by her brother cos her parents have died, and his wife, and his niece, they're all living together, the extended family, the niece is pregnant..and she's got 2 small children and the main thing that was coming through was that you know...cos my patient...the disabled girl..she'd had a fall in October ...so she's actually got a plaster on ...she broke her arm...so ...but she's fine.

...and but you know...the, the brother and the sister in law find it really difficult to manage her care because they've got no hoist, she's on a standard bed, no bath lift and they're lifting in....and he's talking to me and he's rubbing his back...and I said ok the first thing I'm going to do is sort out some equipment...so oh...right great! So they were happy about that already sorted cos again...equipment loan know what works really well and they're very good...wheel chair...they had a wheel chair that was given to them 20 years

ago so I call it the 3 legged wheel chair because it's in that bad a condition so again I've had to get in and really grovel to wheelchair to get a wheelchair brand new one cos she needs...she doesn't walk, she's disabled and that's her mode of transport from bed to bathroom, outside in the summer and these people were managing .

...and then like on top of all that it was just a conversation they were saying you know...and the sister in law were saying ..period times are terrible...each month because they're so heavy and it's such a mess and she doesn't like it and she doesn't know what's happening ...so I've seen a clinical need, so I've give a depot...so now I'm hoping obviously her periods will stop so that will take some pressure off them...so for me that could have been offered years ago, I'm not saying it would have made...well it probably would have made a big difference to how they care for her in the future now because it's gonna be a lot easier because we've all...we've had a good talk...I've contacted social services, gonna get a social worker and put a care package to help with her toiletry needs, washing, feeding, probably 3 calls a day, we've discussed what would help them as a family unit and so that's what we're planning now, so you know, all these little things and you know they're so grateful and I've only met them a few times and they're just so grateful.(Isobel: community matron, area 1, p4: 193-225)

Both these examples show the complex nature of cases which community matrons work with and the coordination involved in helping individuals, not just with health needs but also social and emotional needs as well.

The next sub section considers issues surrounding hospitalisation as perceived by community matrons and patients and carers.

6.53 Hospital admissions

As noted in the introduction to the thesis, changing demographics, an ageing population and a growing incidence of individuals presenting with co-morbid long-term conditions requiring hospitalisation has increased the burden on the NHS. In this sub-section findings from the mixed methods design are presented.

The initial hours worked by community matrons of 9am to 5pm Monday to Friday also exacerbated difficulties associated with out of hours requests for help which often led to emergency admission to hospital (Rachel, manager, area 3). A great impetus with the introduction of the community matron role was their presumed ability to maintain individuals with long-term conditions in their own homes. How to measure this proved difficult and according to Rachel, commissioner in area 3, this persists:

'And I do remember us at the time having discussions with the then PCGs around the definition of an avoided admission which did take a huge amount of time for both parties to agree that that's what it was and then we did agree and use that with the CMs and keep a list of people we felt fell into that category that we felt demonstrated the

effectiveness of it. But we still have those discussions over avoided admissions and nationally that is one of the biggest dilemmas in the schemes and projects which are set up to get a common understanding of what is an avoided admission and how to measure that as well' (Rachel: manager, area 3, p1:36-42)

That patients valued having an identified 'port of call' who they could contact at times of exacerbation increased their confidence to self-manage (Sophie and Lyn, GPs area 3) and it was perceived that this kept some individuals out of hospital (Sophie and Lyn, GPs area 3), although James (GP area 2) was non-committal on reduction in admissions as a result of the CM service. The findings of the GPs in my study differ from GP views in Iliffe et al.'s (2011) work which showed the dominant view of GPs to be sceptical of nurse case managers' ability to reduce admissions to hospital. Community matrons knew that they were being measured against the metric of reducing hospital admissions, as shown by the following comment:

'if you talk to the managers, if you talk to the commissioners, if you talk to the GP's the outcome clearly is to stop people going into hospital,' (Geri : community matron, area 1, p4: 142-144)

However, there is a concern from community matrons that they are often measured against their ability to prevent hospital admissions when in fact some are necessary:

'because actually it's a very necessary hospital admission, you know, they have a CO2 retainer and they have an infected exacerbation then they need to go into hospital, you're never going to change that so I do find that a bit frustrating sometimes because I do think people just think that you can just wave your magic wand and prevent it all, and it is much more complex about that' (Liz: community matron, area 3, p6:204-208)

The issues encountered might be managed at home, but as Natasha highlights, if you have a patient who does not like HCPs in his home, then it is hard to proactively manage a complex situation, so here the only answer is hospitalisation:

I actually...need to admit him to hospital to get him investigated and to try and put him on some sodium bicarbonate to make sure that it ...hopefully balances out his renal failure or probably need IV fluids to try and balance out the acidosis that he'll have as a result of the renal failure. This gentleman is extremely resistant to health care staff going into his property and he's basically just wants to be left alone...we've got the task now of trying to convince him to go into hospital...I've already spoken to my colleagues at the hospital cos they reported the blood results to us cos obviously they were so badly deranged, and I've also spoken to the renal registrar on call who has agreed to see the gentleman should he go into hospital today (Natasha: community matron, area 3, audio diary, entry 12)

This shows that not all patients are in a position to accept partnership working to

improve their health.

As a means of exploring how effective community matrons had been at reducing hospital admissions in area 1, an examination of PARR data was undertaken as part of the parent project. In the first instance this explored patient journeys. Patients, carers and community matrons in area 1 had given many examples of what they considered to be saved admissions. Such an example was given by Heidi, a community matron who reports ringing the on call resident medical officer (RMO) to discuss a patient and her treatment decision to ensure that this seemed appropriate, or whether the RMO felt that admission was required. The outcome was to maintain the patient at home, which was successful, thus preventing an unplanned admission. Sometimes, matrons report a requirement for patients to be admitted to hospital where a clinical need cannot be met in the community. Thus the admission becomes an appropriate admission, rather than an emergency. Close relationships were apparent with the renal unit in area 1, whereby a community matron's knowledge of patients is such that when an exacerbation occurs they are able to facilitate a planned admission, which prevents a medical crisis. Similarly, a patient noted to have a post heart surgery wound infection was re admitted to hospital in a planned and managed way following liaison between the community matron and the surgeon about the swab results.

Examples here offer a rationale for data collection and how the findings have been considered from the qualitative and quantitative parts of the study. As such, because of the qualitative reports of saved and also planned admissions, patients who were interviewed as part of the study in area 1 had their records in the PARR data analysed.

The 13 patients who were interviewed for the parent project also consented to their PARR health records being examined. As this data only appears anonymised in my doctoral work, the data have been re-examined. In undertaking this exercise I placed emphasis on the number of days spent in hospital before and after case management by Community Matrons. The findings are tabulated below:

Patient	Number of months PRE-referral to CM service	Number of months POST referral to CM service	Days spent in hospital PRIOR to case management by a CM	Days spent in hospital POST to case management by a CM	PARR score range over case management period	PARR score (1/5/ 10)
1	38	9	138	0	50-76	50
2	35	12	5	3	54-72	64
3	1	32	12	69	56-86	66
4	6	15	5	0	21	21
5	11	15	36	0	39-42	42
6	44	11	427	0	51-80	51
7	34	15	30	10	50-79	68
8	*	*	*	*	*	*
9	32	15	56	0	68-78	68
10	11	11	14	0	30-44	30
11	34	15	10	11	43-62	47
12	1	10	1	0	19-46	19
13	17	15	29	19	75-89	78

Table 28: Interviewed Patient's Journey (area 1) from PARR Data (2004-2009)

(patient 8 * no hospital admissions therefore not on PARR)

The findings show a reduction of days spent in hospital in 10 out of 12 (83%) patients. By examining patient journeys from PARR data alongside patient and informal carer report of less hospitalisations, there is evidence that patient/ carer perceptions are accurate. Similar reports from qualitative data of community matrons also noted many 'saved' admissions. As a consequence, PARR scores also showed a reduction in these patients over this period. As a result of these findings, a larger sample of patients was considered (methods section 5.31, analysis section 5.7) and the findings are as follows:

Intervention Group and Comparison Group

Descriptive statistics for the intervention group (1) show that the average hospital stays in the high PARR risk score patients was 37 days (mean 37.38). This was similar in the comparison group where average length of stay was 36 days (mean 36.34). Average length of stay in the PARR medium group of patients was 29 days (mean 29.13) in the intervention group and 23 days in the comparison group (mean 23.46).

By examining the median in the intervention group, the high risk group of patients had hospital stays which exceeded 27 days (median 27.00) in half the sample whilst in the comparison group half had hospital stays in excess of 20 days (median 20.0). For the

medium risk patients, half had hospital stays of more than 14 days (median 14.50) in the intervention group. In comparison the median in the comparison group showed half of medium risk patients being hospitalised for more than 13 days (median 13.0).

A Mann-Whitney test was performed using the following questions in relation to the data:

Q1. Do medium and high risk patients differ in the number of bed days in the **intervention** group?

Q2. Do medium and high risk patients differ in the number of bed days in the **comparison** group?

Q3. Is there a significant difference in hospital bed days between **intervention** and **comparison** groups in relation to PARR medium patients?

Q4. Is there a significant difference in hospital bed days between **intervention** and **comparison** groups in relation to PARR high patients?

Pallant (2001) states that the figures of importance in the outputs produced are the Z value and the significance level (Asymp. Sig [2-tailed]). These values are presented in table 25 in relation to the 4 questions asked.

	Q1. Hosp days/int	Q2 Hosp days/comp	Q3 Hosp days/PARR med	Q4 Hosp days/PARR high
Z value	-1.816	-2.051	-.047	-.415
Asymp.Sig (2-tailed)	.069	.040	.962	.678

Table 29: Z value and Asymp. Sig for 4 questions

With significance set at .05, the p values (p=.069 for question 1, p=.962 for question 3 and p=.678 for question 4) offer results which are not significant. So there is no significant difference in hospital days between medium and high risk patients in intervention group (Q1). In addition, there is no significant difference between

intervention and comparison group in relation to bed days for PARR medium patients (Q3) or PARR high patients (Q4).

However, with significance set at .05, the p value for question 2 is less than .05 ($p=.040$) so this result is statistically significant meaning that there is a significant difference in hospital days between medium and high risk patients in the comparison group.

The SPSS outputs can be seen in appendices 9, 10 and 11. Had the findings been significant in all enquiries the need to undertake a far bigger examination of patients recorded on PARR data and the relationship with being on a community matron caseload would have been a logical step. However, as the results stand, it seemed appropriate to include this small quantitative part of the study, but to further examine qualitative data from 2 new areas in relation to the community matron role in reducing hospital admissions did not seem appropriate for reasons noted in the limitations section (5.8). Discussion of this aspect, albeit brief, is made in section 7.2.

Another factor which impacts hospitalisation is that of out of hours cover and this is explored next.

6.54 Out of hours issues

These issues were particularly noticeable in area 1 from the data collected as part of the parent project and then re-analysed for my thesis. In area 1 community matrons were working to the original model which meant a Monday – Friday service from 9am to 5pm. As Veronica notes in her audio diary there is recognition of the issues from working limited hours, but also a frustration that the out of hours service does not always support the ethos of keeping patients at home:

*‘again became more breathless, she hadn’t been taking her inhalers, and was admitted into Selly Oak hospital via the out of hours doctor again...I recognise how challenging it is for out of hours doctors to sort of turning up and assessing people and left with little option really. I think what was interesting is that both out of hours calls were made on the Saturday night ...our service doesn’t work in the evenings or at the weekends’
(Veronica: community matron, area 3, audio diary p4:202-206)*

Additional audio diary entries provided further data. Issues surrounding out of hours seemed to provoke frustration in the matrons who could commonly see a solution but were unable to make major changes. These frustrations were great because the

community matrons in area 1 knew their service was being evaluated and one of the metrics being used was that of preventing emergency admissions to hospital. Natasha's audio diary stated two dilemmas, firstly that out of hours doctors rarely visited patients, and so were not making an assessment which could have been assisted by records in the house:

'he'd actually initially had rung the out of hours GP which they obviously didn't know the patient and so advised him to call an ambulance... which was in the early hours of the morning...' (Natasha: community matron, area 1, p5:196-198)

Secondly, a frustration around patients who are end of life and continued to be admitted to hospital out of hours:

'I do feel that there needs to be a lot more improvement around those who suffer from COPD in particular and those with HF when they're at end stage cos often they are sent to the hospital and that's due to the fact that they come ...against a crisis at home and usually it's in the early hours of the morning a relative will ring the hospital ...ring the ward or the hospital to get some advice and they'll tell them to go in...and usually then they're in hospital and they're...obviously there's an active treatment programme in place when not realising that they're ...they're actually end stage' (Natasha: community matron, area 1, p11:480-482)

As mentioned, the introduction of a virtual ward model in area 3 with increased hours and across 7 days a week was seen as positive in managing the out of hours period.

Chris, community matron in area 3 states:

So if you've got a service that's operating in the community matrons traditional way then what happens to those patients in the evenings you know out of hours don't really go and visit very often, they just tend to admit people, so in a way all the work that's done by the community matrons in the day is possibly compromised on evenings and weekends. Whereas in the virtual ward we actively encourage people to ring us up till midnight, 7 days a week to try and minimize those admissions. (Chris: community matron, area 3, p3:126-131)

The compromise mentioned by Chris, in her comment above, is the crux of what the community matrons in area 1 were seeing with what they perceived to be fragmented care. Community matrons in area 1 strove to keep their patients out of hospital and then with other services not having the same ethos this often resulted in out of hours admissions. Positive impact on emergency admissions is noted as a result of the VW and again in area 2 this time, the extension of hours and to a 7day/week service through fast response has lead one matron to comment:

‘..that is a bit of a relief yah because otherwise they’d be left and then they were going into hospital on Saturdays and Sundays so that has helped.....I can honestly say my patients have stayed at home and I haven’t had a patient go into hospital for several months now.’ (Ellen: community matron, area 2, p2:57-58; 384-86)

Generally, patients appear to prefer to be cared for at home. As Ava relates:

the hospital ...I just prefer it at home’ (Ava: patient, area 2, p1: 18 and 25)

Maud expresses the strategy she puts in place to try and prevent an admission, although she finds it difficult to stop her husband phoning for help:

‘Oh yes. He’s want to call them straightaway but I think once I’ve rested there’s no need for them because they only send you straight in & soon as you get in they are waiting to get you out again.’ (Maud: patient, area 2, p5:122-123)

Issues around out of hours are noted by community matrons and patients:

‘he’d actually initially had rung the out of hours GP which they obviously didn’t know the patient and so advised him to call an ambulance which was in the early hours of the morning...’ (Natasha: community matron, area 1, audio diary, p 5: 196-197)

Difficulties accessing out of hours help are also noted as challenging. Nina describes having to know you are going to be ill on a Friday so that help will be available. Models such as virtual ward and fast response with 7 day working have impacted this however. Ellen notes that this offers a sense of relief to matrons to know that one of their colleagues will be in fast response at a weekend and can help to solve issues that arise, albeit not the actual role of fast response.

Through service redesign and changes to the role of community matrons there have been some positive changes reported in relation to impact on emergency hospitalisation of patients with long-term conditions. These reports are from qualitative data and areas 2 and 3 largely back up the finding from participants in area 1 who gave examples of ‘saved’ admissions.

Part of service redesign saw the implementation of policies to manage discharge from caseloads. Additionally discharge from hospital also impacted community matron work and findings which consider both aspects of discharge are presented next.

6.55 Discharge

This is explored in relation to discharge from hospital and the positives and negatives associated with this process on the community matrons. Secondly it explores discharge from caseloads and how this is viewed by patients, carers and community matrons.

To be expected the community matrons offered good and bad examples of hospital discharge. As a positive, Megan notes:

'I've been into see the patient and had documented my details in the medical notes for contact when the patient was discharged, so I had a phone call today from the ward to say that the patient was in the process of being discharged and just to let me know so I could resume care on her discharge today.... pleased with this outcome as it's been a struggle to really get into secondary care.' (Megan: community matron, area 1, audio diary, p4: 201-207)

Conversely, her colleague Lauren reports a very difficult situation despite going to the same lengths of making the ward aware that the patient had a community matron:

'There's been certain circumstances have been very poor ...I've gone to the ward, phoned about 12 times, I've written in the notes about 3 times and they still haven't phoned me. One particular ...they dumped her out Friday night ...locked her in...cos again she had cognitive impairment, no heating, no lighting, no food, nothing all weekend, no carers. No one really to get the care package...so she handed the keys out the window to a stranger...then we had to involve the police...(laughs)...so you can see how things get complicated...things don't change unfortunately...people still get dumped out on Friday and Saturday nights ' (Lauren: community matron, area 1, p13: 647-655)

The levels of frustration community matrons feel when they meet barriers from other services shows some of the hidden emotion which involved in the role. Other community matrons in area 3 struggled to come to terms with service delivery changes which meant that patients would be discharged from the caseload. The following quotes show their anxieties:

'Discharge, they discharge patients and I just do not agree with that. I mean GPs don't do they? If you've got a chronically ill patient on their case load or on their books they don't discharge them after, oh you've had an episode, you're better now, you're chest infection is improving, I'll discharge you'. (Lucy: community matron, area 3, p7: 252- 255)

Liz adds her thoughts on the issue of discharge:

'when you think somebody with COPD from diagnosis has probably got prognosis of 5 years, heart failure 2 years, if you actually want to give them any quality and length to life really your intervention needs to be ongoing and supportive for that duration really and sadly these people don't fit into anybody else's criteria.' (Liz: community matron, area 3, p2: 47-50)

These comments raise many dilemmas. Arguably this changes the nature of the service from proactive to reactive, and will be discussed in the discussion chapter. However, despite the concerns of community matrons, a patient and his wife had experience of discharge and although the wife felt it left the carer with a lot of responsibility, they did agree that one phone call had led to a visit and re- instatement on the VW. With the exception of these reflections by Ray and Mary, other patient and carer participants had not noticed any difference in the level of care received, although not all participants were part of the same service delivery changes.

Part of the patient journey, when living with a long-term condition, is the ability to self-manage and be as independent as possible. Findings from participants in relation to these aspects are presented next.

6.56 Self-management and independence

A large proportion of the community matron's time is spent working with patients and families to increase self-management and as a result to promote health and prevent ill health. One of the key skills which patients require is being able to understand their own disease pattern. Many patients are active self-managers, often able to pick up warning signs of exacerbations which they convey to their community matron. This example shows partnership working between the patient and the community matron and illustrates the strategy of using a diary to focus the patient and collate information:

'...how he felt that in first instance he was actually not feeling very well..what first happened to him and we kept a little diary and it was obvious with every exacerbation that he had..in the first instance he said he actually went off his tea in the morning which was really a fantastic marker that he was going to exacerbate...and with that...we actually then he used to call me immediately..listen to his chest...yes he'd got a temperature and we started off the antibiotics and steroids...now this is a gentleman that used to go in and out of hospital nearly every 4 to 6 weeks with exacerbations or with particular problems and to date in the last 18 months he hasn't been in once so I do feel that is very much admission avoidance by us and us I mean the patient and myself..' (Megan: community matron, area 1, p8: 420-426)

The impact of this strategy is that the patient can recognise exacerbation early and prompt treatment can be sought. Self-management improves and increases independence for Megan's patient.

Patients and their carers talked a lot in relation to autonomy and coping although often

without realising that they were doing so. Patients and carers were asked about their understanding of their diseases and medications and how confident they felt in gaining help if unwell. Rory states:

‘Any increase in weight is a sign that my ticker is going dicky’ (Rory: patient, area 3, p 1:31-33)

As seen in Rory’s answer (above), generally their answers demonstrated an ability to self-manage and to be as independent as possible.

As noted in the section on medication, many patients had their medicines organised in dosset boxes which allowed them to keep track of their medicines. The organisation of their medicines in this way was usually by the CM/VW. One patient mentioned taking his medicines ‘*religously*’, but did own up to occasionally missing his lunchtime insulin dose if he had visitors, so in a sense being concordant as long as it fitted in with his life.

Another patient had developed his own system of recording the use of a rescue pack for chronic obstructive pulmonary disease (COPD):

‘I write when I take them; say like I start on a particular day and finish on a particular day I write it next to my diabetes blood sugar.’ (Patrick: patient, area 3, p3:85-87)

In this way, Patrick is contributing to his care by providing an accurate record of what has been happening to his long-term condition. Increasing independence was also noted in carers too. The combination of developing independence appeared to be enhanced by the knowledge that support was available from the community matron, as evidenced by an 85 year old carer:

‘I didn’t phone the Community Matron, because I could manage this by myself, but it is reassuring to know that she is behind me.’ (Edie: carer, area 1, p4:188-189)

The relationship with the community matron has allowed Edie to develop self-management skills and it has promoted independence. Although a lot of data points to effective self-management and independence, there is a danger that patients can become dependent on their community matron. Jess reflects:

‘but it is about empowering them and realising yourself as well recognising how dependant they are becoming and pulling back a little bit and just saying to them you got through it look you did it and then that helps them to face it the next time then they don’t panic much, it is fear really, and they have had bad experiences a lot of them

though poor health, through maybe services not meeting their need, and it is about building their confidence bigger' (Jess: community matron, area 3, p5:188-192)

Being aware of the risk of dependence allows community matrons to utilise strategies to reduce this and increase self-management and independence. The issue of dependence was also noted by an area 2 commissioner as being an issue early on after the role was set up:

'one of the biggest issues was dependence you because everyone was very focused on keeping people out of hospital and I think what they found was short of taking patients home with them to keep them out of hospital you did have a very strong relationship with the patients and I think what they found it was very difficult was then to stop the patients ringing them every time that they needed something so I remember one of the things early on was how you worked with patients to get them self-caring as much as possible and trying to reduce reliance on community matrons.' (Emily: commissioner, area 2, p2: 40-45)

For Liz, there is evidence that patients want to try and manage themselves effectively and seek appropriate help so that they do not get admitted to hospital:

'once you started becoming involved as a community matron that never happened again because they did learn to manage it and most people actually want to stay out of hospital they don't actually want to be calling the ambulance, they don't really want to be ending up in A&E on a trolley for hours to be turned round or lost in the system.' (Liz: community matron, area 3, p5: 195-198)

But for Kate there is a dilemma in that patients are used to being told what to do and often react too late:

'patients are used to reactive so it's quite hard to sort of educate them' (Kate: community matron, area 1, p5: 223-224)

Kate's comment encapsulates a big change in expectation for many patients from paternalism to partnership. Changing mind-sets takes time and as such it may be expected that exploring impact of the community matron role on this patient group will take time also. It is noted by Wilson et al. (2012) that perceptions of being managed by a nurse led service were often shaped by what was familiar to the patient and in this case a paternalistic model rather than a model built on partnership. Overall, data collected from semi-structured interviews highlighted a greater sense of autonomy and independence in this group of individuals with fragile health as a result of their long-term condition than might have been expected. This will be explored in greater depth in the discussion chapter (section 7.4).

6.6 *'I can't walk away': the invisible role of the community matron*

The term invisibility is one used by Liaschenko in relation to work undertaken by nurses, but as reported earlier is work that is hard to show. I interpret Liaschenko's sense of invisibility as more structural rather than about inter-personal relationships. The question is whether the work is invisible or not there. Findings based on participant contribution state almost unanimously that it is the former: invisible. As such, my thesis explores invisibility in relation to the role of community matron and explores value of the role as seen by patients and carer, emotional impact on community matrons and time taken to achieve outcomes.

6.61 Value of community matron work as seen by patients and carers

Many aspects of this have been presented elsewhere. Presented here are examples of work which exceed the boundaries and yet is valued by patients and carers. Most are simple examples including fetching of and organising prescriptions:

'on one occasion I think she actually fetched them for us' (Nina: carer, area 3, p2: 47)

'and when we've been ill she's gone out and got us prescriptions and bought them back herself..., when like when I was on the cancer treatment' (Pam: patient, area 1, p9:285-286)

The next example is from a more erratic patient who admitted:

'it happened that I ran out of tablets and I phoned her a bit late and she said I've finished work now...I said I'm sorry Lauren I do apologise for that...she says well I'll see what get...?? She phoned up the doctors like and sent em out for me straight away like...fair play to her like but I put the phone down on her

the next day...she told me off which was fair play to her...what I was expecting anyway...' (Harry: patient, area 1, p 4:103-106)

The strength of relationship and the trust he shows in his matron is shown by the fact that he took his reprimand in good part. It also shows the lengths that community matrons will go to for individuals on their caseloads. This is likely to have an emotional impact on the matron and such issues are explored next.

6.62 Emotional impact on community matrons

Managing fragile high risk patients in the community is stressful. This stress emanates from many different situations. The stress of some may be more obvious to outsiders

than smaller incidences. One such example of an everyday time occurrence is given by Liane:

'you might have to leave 15 phone calls and ring every day because it's very easy to say well I've made a phone call it's up to them to get back to me, you know you've got to be quite tenacious to get these things sorted and you've got to be able to challenge.' (Liane: community matron, area 2, p5: 147-150)

What Liane describes is a common occurrence where she is not able to complete her role because she is relying on others to take their part within the care of a patient. This leaves her feeling under pressure that nothing was being completed. Other examples, such as clinical incidents are more obvious in relation to the emotional impact on community matrons:

'A patient who advised that his nebulized machine had fused and not fused just the machine but his whole house..he'd since been to his next door neighbour who thankfully was an electrician and was able to put in new fuses for the house but certainly his nebulizer ..he informs me had burnt out. Because of the need of this gentleman's nebulizer he has a permanent tracheostomy, so the patency of that trache is imperative ...I assured him that a replacement nebulizer would be in his home today

I received another telephone call from Mr and Mrs X, very anxious and concerned that they had not yet heard anything or received any sign of a replacement nebulizer naturally I was extremely disappointed and frustrated but I assured them that I'd get onto it straight away and get hold of a nebulizer. Obviously this was following ensuring that Mr X himself was ok...that he had not run into any respiratory difficulties although the longer he was done or he was without nebulizer therapy, it increased the risk of his tracheostomy blocking off.

Immediately I attempted to contact the intermediate care team who I'd spoken to in the morning, unfortunately they had shut up shop and had left for the day... I then went on to speak with the staff at (name) who were very helpful and assured me there was a nebulizer available should I need it...at that point I then decided that I needed to really bring this to the attention of the on call manager ...and to inform her that ..you know...really I had to establish somebody to pick this nebulizer and get as quickly as we could to Mr X...she was very helpful and said she'd get back to me as soon as she could get hold of someone to do that...I also contacted the evening DNs again really as a second resort to see if I could get them to pick and deliver a replacement nebulizer as it had to be someone who knew how to work the machine and was able to establish if there were any difficulties at this time...fortunately the evening DN was able to kindly do this...and she was also able to collect the nebulizer from [name] and I was thankful for that. I spoke with Mr and Mrs X and reassured them that she would be arriving in their home within the hour and that this would be done.

After that call I felt it was only right professionally and certainly from a safety point of view that a clinical incident form be filled out because of the length of time and the risk to the patient but I also had established that there was huge breakdown in

communication with the intermediate care team and the loans department and also with [name]'. (Heidi : community matron, area 1, p3: 90-140)

An incident of this magnitude is not an everyday occurrence, but nevertheless shows the types of emotional pressure felt by community matrons. Complex clinical situations are commonplace and form a part of the community matron role. Trying to keep patients with fragile health in their own homes safely is a big responsibility. As coordinator, Heidi's example shows the pressure felt by them. In her audio diary, Kate describes the fragile balance in keeping a patient at home. It demonstrates the delicate balance required and does impact on the community matron's emotional wellbeing:

'he's got multiple LTCs,, but his main one is Chronic Kidney Disease stage 3 and Heart Failure (HF) and I think the HF has knocked out his renal function...so he's on a bit of a catch 22 ..he fills up with fluid, increases diuretics and it knocks his renal function off so we have to decrease his diuretics and then he fills up with fluid...he's got a very sort of narrow window between sort of the fluid overload so I have to sort of monitor him quite carefully.. a sensible man so he knows when he's starting to fill up with fluid so he contacts me quite readily and I go and increase his diuretics ...but then obviously take blood to monitor his renal function...he is known to the Renal Team so again he's monitored quite closely with them..my visits..I do feel that stop a hospital admission' (Kate: community matron, area 1, audio diary: day 3)

Other everyday issues impact community matrons. Liane reports taking on a referral which really wasn't a suitable referral for her:

'I do really believe that you need a key worker/ case manager approach to complex conditions because you have to have somebody that is prepared to take on and be the liaison point with all the different services and I've got a lady that I'm seeing at the moment that has MS. Now she doesn't technically fit my criteria but I was asked to get involved by the Occupational Therapist who was struggling to deal with social services, so I ended up getting in at that higher point and saying right this needs to be sorted out her care package is inappropriate because it's not resolved, this is going to be a safeguarding issue. You know things get moved on very quickly once you've mentioned safeguarding so I'm still involved but really that's all I've done is be sort of the organizer and I think that is really an important part of our role.' (Liane: community matron, area 2, p4:136-145)

Here Liane fills a gap to support a colleague in order to gain the best outcome for a patient despite it not being her job to do so. Such arrangements are not always met with reciprocality as another matron reports that referrals are not always accepted by other teams and she reflects that:

'obviously I can't then walk away because if they're not coordinated and resolved then they could end up in hospital.' (Anna: community matron, area 2, p4:138)

Unrealistic expectation by patients and carers can make the role emotionally challenging too, and the following quote shows the importance of effective communication to protect both community matron and patient from unrealistic expectations:

'I think sometimes it is very difficult with this job because you want to be able to provide care for these patients but sometimes patients and families can be unrealistic about the services which are available and a lot of our job is explaining to people what they can and can't get.' (Liane: community matron, area 2, p3: 107-109)

And impact of working as an autonomous matron with no back up at busy times can result in a lesser service which adds emotional stress on to the matron. Grange (2011) considered that managing caseloads of 50 plus can move community matron practice from its intended proactive approach to a reactive one as highlighted by Sally:

'I've been a lot less proactive because I've been so busy trying to manage peoples exacerbations that it's ended up being a bit more reactive and because I've had, because there's no one else for me to say look I'm struggling a bit would you mind going to see somebody because I haven't got any staff, everything comes down to me so if I'm busy with lots of ill people unfortunately the time spent on education other than a little quick explanation has to go, or has had to go by the board a little bit.' (Sally: community matron, area 3, p5: 168-174)

The advantages of working in a team can be seen in this instant. However, moving from working as an autonomous community matron to the virtual ward was difficult for some matrons. Lucy noted that:

'I felt I lost my identity of being a community matron.' (Lucy: community matron, area 3, p2: 82)

Other work related issues include supporting patients and carers in a way which could be deemed at the boundaries of the role:

'have offered to go and visit him in hospital with her (wife and family carer) to try and support her and to discuss any discharge plan.' (Sally: community matron, area 3, p3:116-117)

As well as accompanying the above carer, the quote below shows the matron working to help a patient because she is trusted to do so by the patient:

'She had rung up the pensions company but because she is deaf and has a speech impediment they put the phone down on her and we have spent about 45 minutes today sorting out the fact that her pension had been suspended because a letter had been returned to the pension service from her house that she had not opened and they had assumed that she was unwell or in hospital or had died and so suspended it which caused

her great difficulties paying her rent and she has had to borrow off friends and she says that really she has been too scared to tell anybody and she hasn't known how to cope with it and if it hadn't been for the community matron coming round that she felt she had a good relationship with, she thought she would bring the problem to me and we have managed over a couple of sessions, to be fair, to sort it all out and get it re paid and she has a payment of £750 into her account and everything is working smoothly' (Sally: community matron, area 3, p4:139-152)

Again, Sally's example takes the community matron outside her remit, adding to her workload, but without doing this the patient's situation is likely to worsen causing additional work for the matron.

These are just some examples of work which community matrons undertake, rightly or wrongly. The emotional impact of this can be seen. How some of these examples are documented is not clear, in order that they are seen by a wider audience. Finally, findings which relate to the amount of time taken to undertake aspects of the role are presented.

6.63 Time: in relation to documentation and care coordination.

The audio diaries offered community matrons the opportunity to discuss the time consuming nature of their work amongst many other aspects. There was certain angst in relation to number of visits undertaken as Kate highlights:

'the people that we've seen in the day, the commissioners look at it and all they want to know is that we've seen x amount of people in the day but it shows that you know you could spend two hours with one patient, and the commissioners see one patient instead they'd probably like you to see 5 that only take 20 minutes.' (Kate: community matron, area 1, p5: 209-212)

Trying to liaise with other agencies also took a large amount of time:

'I'd say the hardest part of it is communication..people don't talk to each other and trying to find information ..you can spend the whole morning on the phone just trying to find out you know a miniscule detail about a patient.' (Lauren: community matron, area 1, p7:373-375)

A similar issue is recorded by Veronica in relation to the coordination of care:

'this patient ... there's going to be a lot of sort of coordinating of care so ...because there's a lot of agencies involved here ... a lot of people involved so it's just making sure that they all sort of tie together and that we are really acting as support of ... the patient and his wife who's the main carer... I was with that patient around about 70-80 minutes and then following that a number of hours were spent with sort of following up all the phone calls.' (Veronica: community matron, area 1, audio diary, p5:267-271)

All these factors contribute to show how difficult it is for the community matron to express and record the role. By taking a patient centred approach the data also shows how this can bring the matron beyond the boundaries of healthcare.

6.7 Chapter Summary

This chapter has presented findings from the major qualitative aspect of the doctoral study, the patient journey aspect of the work and the smaller quantitative aspect.

Findings from the examination of patient journeys revealed an impact on hospital bed days as a consequence of having a community matron. Such findings were not replicated in the larger data set, which were examined using SPSS 20. As qualitative data from the parent project gave many examples of proactive practice which was considered to have an impact on hospital admissions as well as offering many other examples of work undertaken, this data was re-examined. Qualitative data was collected in a further 2 areas.

The qualitative findings have been analysed through a framework and are presented thematically. The themes are implementation of the role and effects, the delivery of health care by community matrons, psychosocial aspects of living with an LTC, the patients' journey and invisibility as it relates to work undertaken by community matrons and show the depth and breadth of issues associated with the community matron role.

A discussion and interpretation of the findings follows.

Chapter 7: Interpretation and Discussion of Findings

7.1 Introduction

The discussion chapter builds on the literature reviews which examined case management and invisibility and discusses responses made by participants to the questions which were formed around the case management domains. Links to themes identified in the invisibility literature are most notable in my work in relation to nurses views of their roles, invisibility as harmful and the use of language surrounding what nurses do and how it is articulated. As such, my work builds on and adds to the existing body of work. The language aspect has a synergy with the work of Liaschenko and Fisher (1999) who express the importance of ensuring a common understanding of nurses work which , in turn would make the work overtly visible and therefore, I contend more likely to embed. Although the findings from my work show complexities of work undertaken by community matrons that is not always seen or understood and marries with Liaschenko's findings, my own work adds a further idea. Rather than the work done by community matrons and indeed their role not being seen, there is an additional element that work undertaken in a community setting is equally poorly understood and this compounds embedding partly because of limited visibility.

Having formulated the following themes:

- *'Agreeing ways of working without understanding'* : implementation of the role of community matron and effects
- *'A little bit of extra effort'*: the delivery of health care by community matrons
- *'Climbing Mount Everest'* : psychosocial aspects of living with a long-term condition
- *'A jigsaw of care'* : the patient's journey
- *'I can't walk away'* : the invisible role of the community matron

I found the story evolving on three levels. These levels were macro, meso and micro. Defining them as I saw them meant that macro incorporated the 'bigger picture' and

came from influences evolving at a national level. This seems to me to link effectively with the first theme of implementation of the community matron role and effects. Meso incorporated a middle level at which local organisations (health trusts) made operational decisions which were impacted both from national level (macro) and the micro level feeding back up. This resonates with the second theme: delivery of healthcare by community matrons. The micro level then can be seen as what happens day to day at the grass roots of care delivery based on relationships between community matrons and the patients on their caseloads. This micro level incorporates the themes: psychosocial aspects of living with a LTC, patient journey and invisibility of community matron work. Each level has the potential to influence the other levels. This can be seen in visual form in appendix 15.

Although I find the concepts of macro, meso and micro interesting, I considered that readers may feel less enthusiastic. My experience from the classroom has led me to realise that in order to establish engagement with such ideas I somehow have to root them in the daily work of the students in order that they appreciate the significance. So, I came back to Liaschenko. Liaschenko and Fisher (1999) speak of case, patient and person; all words which would have some resonance with nurses (and other health care professionals). I wondered if I could make links.

In fact, what I present here is an amendment of Liaschenko and Fisher's work, because although I did not find an exact fit, I felt that there were enough parallels to offer an alternative. For me, case, did not fit with the macro in the sense of my study, so I have named the macro as policy. Although this also includes local policies, I consider that the policies exist in an overarching sense for the local health trust and hence it is 'macro' to them. Meso, however, does represent patient, by exploring how healthcare is delivered to them. The micro level, then, represents person and refers to the individual living with ill health. I have taken this a step further by including the community matrons who participated in the study if their experience showed impact on them as individuals and thus 'person'. I argue that they can be vicariously living with illness as a result of their daily work.

Aspects of policy, patient and person are impacted by or impact on the visibility/invisibility of the work of community matrons in caring for vulnerable individuals with long-term conditions. Thus issues pertaining to visibility or invisibility can be seen to cross macro, meso and micro levels. This will be demonstrated further as this chapter progresses. Diagrammatically, this can be interpreted as follows, with each area closely linked to another:

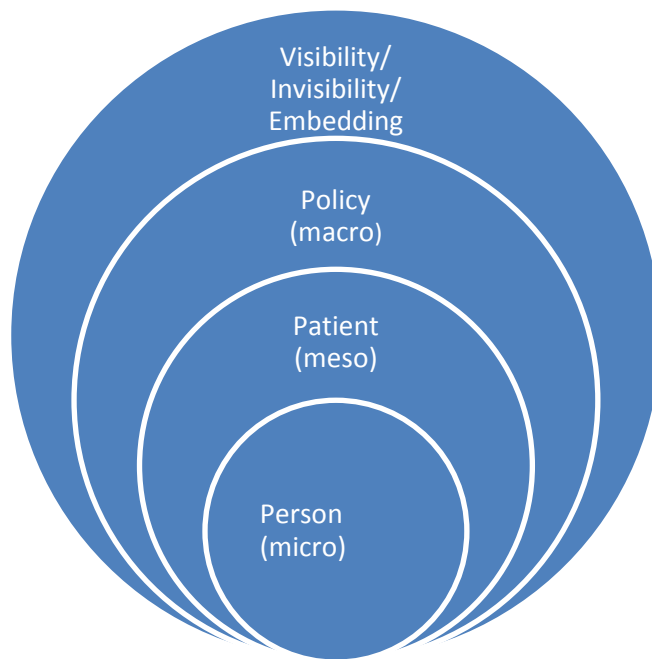


Figure 20: Adaptation of Case, Patient, Person (Liaschenko and Fisher 1999) to Policy, Patient, Person in light of doctoral study findings

So, in this chapter, I offer my interpretation of the findings. Where findings are similar to previous studies, I have linked them to this literature. Where new ideas emerge, I have given my own explanations backed from the data in the study. Links are made back to the research question and the study objectives. I have chosen to present the discussion set out around the themes of policy, patient and person.

7.2 Policy (macro)

Through qualitative interviews, this macro theme yielded the least data, but perhaps not surprisingly what was presented came from commissioners and managers of the community matron service, largely. The community matrons did comment on integration as it affected working relationships with other health care professionals. The areas which I consider fit under this overarching theme can be seen, with definitions in

Appendix 9. These comprise: role and skills, hospital admissions, case finding, capacity, integration and whole systems working encompassing working relationships between HCPs and commissioning.

7.21 *'Agreeing ways of working without understanding': implementation of community matron role and effects*

As noted in the introduction (section 1.12) changing demographics and changing patterns of disease within a growing elderly population and increasing numbers of individuals with long-term conditions resulted in a plethora of policies about effective management of individuals with LTCs. Although many health care professionals and other agencies were working with individuals with LTCs, community matron and manager participants suggested that no one had an overview and therefore services received were often fragmented. This was a particular problem for individuals with co-morbidities rather than for those who had a single, defined LTC (DH 2005a). As the NHS Plan (DH 2000a:27) notes, old fashioned demarcations mean some patients see a procession of health professionals resulting in unnecessary repetition of investigations and a lack of information sharing. The introduction of the community matron role and the use of case management was one means of addressing this issue. The idea emanated from the Department of Health and was first mooted in the NHS Improvement Plan (DH 2004a).

In findings, managers report a reticence about being 'told what to do'. There are perhaps two issues here. Firstly, many policy directives are broad acknowledging that any initiative should be universal and yet reflecting that one size rarely fits all (DH 2008a: 18). This allows for local variation in relation to population need and could be argued to be a pragmatic approach, allowing local health trusts to take their own view of what works for their area. Drennan et al. (2011) concur suggesting that consultation and acknowledgement of local nuances is required when new roles are suggested by Government. As Rorty (1979) suggests, there are no universals and each health trust would have its own time and space in which to make decisions based on local population need and therefore an individual context. This would seem a logical approach, but may just cover up the requirement for political expediency. It could be seen as unwise for the government to become embroiled in the minutiae of operationalisation and therefore

be distanced from all responsibility if a policy is seen as flawed. That localism may be prejudiced by traditionalism and socialisation is a potential complexity (Handy 1983: 184). As such the culture of an organisation may hold more sway than a decision based on a firm evidence-based rationale. As Handy (1983: 184) contends, if an organisation has a power culture the balance of influence comes from key individuals who affect decisions rather than procedural or logical grounds. Secondly, since the early 'noughties', some health policy has taken a stance based in corporatism whereby particular interests are considered. High Quality Care for All (DH 2008a) involved clinicians being able to give first hand views on challenges and be involved in presenting solutions. Similarly the National Institute for Health and Clinical Excellence also expects grass root workers to examine best practice and make pertinent recommendations in relation to many aspects of healthcare.

One aspect of the role of community matrons which showed flaws when rolled out in practice surrounded operationalisation. I would suggest that there is clear evidence from the findings in this study which highlight the poor operationalisation as a factor in ineffective embedding of the role. A small number of community matrons interviewed came into role prior to the availability of a key document. This document, the Case Management Competencies Framework (NHS Modernisation Agency 2005) set out competencies associated with the community matron role. The aim of the document was to assist in the preparation of job descriptions and person specifications and to allow the development of educational programmes to support the new role. Additionally, the framework was intended to help managers to monitor and evaluate performance, as well as offering guidance and understanding of the role for those appointed.

An acknowledgement is made in the forward by the then chief nursing officer and the National Director for Primary Care that:

'In defining those competences required for community matrons, this document sets out for the first time, a national standard for a new role at its inception.' (NHS Modernisation Agency 2005:1)

Those individuals in post prior to this document became aware of it and created their roles in accordance. Anna, whose quote is used, was one such matron (section 7.21)

Hence, the findings in my study showed a weakening in the use of this framework, which may in turn make it harder to show what community matrons do. Qualitative data collected in area 1 in 2010 showed a clear knowledge of the framework from all community matrons interviewed. This included matrons who had been in post less than 2 years. However, qualitative data collected in areas 2 and 3 in 2012 was different. Those community matrons who had been in post for a year or less showed limited knowledge of the framework, although t

they were aware of their role in relation to the individual domains. Coming into role, they were presented with services which had evolved and changed as a result of difficulties associated with the original vision (such as virtual ward and fast response; to be discussed further later). However, I consider that non awareness of the framework weakens the position of community matrons in their role. Despite the flaws, case management remains current. Without a clear framework which clearly sets out the remit of the community matron role to other health and social care professionals, the role fails to embed because of constant, albeit well intentioned changes. The role could be considered less visible in line with Liaschenko's observations. This, in part offers answers in relation to the objective examining how the role of community is operationalised through case management.

7.211 Role implementation

Comments in relation to role abound. The inequity of set up in relation to numbers of community matrons in role was noted by managers in area 2. The reader is reminded that the context of the study was presented in chapter 1 and tables show differences in deprivation levels (section 3.4). Number of years as a community matron (table 21) also shows the length of time taken to recruit community matrons. The envisaged recruitment to the role from all walks of nursing did not materialise and, in the first wave at least, most community matrons were taken from the existing district nursing workforce. This only served to leave that group short staffed, perhaps leading to resentment as noted in the findings. However Drennan and Davis (2008) reported that between 1996 and 2006 the qualified nurse full time equivalent number in community nursing rose by 38%; this growth includes the total nursing resource including specialities other than District Nursing. Latest figures from the NHS Workforce Census

(2011) show a 10% drop in DNs over the past year alone and a reduction of 83 community matrons (Nursing Standard News 2012). The community matron role has been divisive with the Queen's Nursing Institute (2012) report stating that some DNs have seen the community matron role as taking over the DN caseload and duplicating their role. In contrast, other DNs see the community matron role as an opportunity for promotion and a valuable asset and support for patients with complex needs (QNI 2012). Both viewpoints from former DNs are reported in the findings by community matrons. The recent publication: *'Care in local communities: a new vision and model for district nursing'* (DH, NHS Commissioning Board and Queen's Nursing Institute 2013) appears to be suggesting that much of the role of community matrons is transferred to DNs. The role of community matron continues to be mentioned, but without conviction in my opinion. This could be seen as a missed opportunity to encourage integration of both DN and community matron services to offer a more robust care delivery to individuals with complex LTCs.

Participants in my study expressed a variety of perceptions of GP views of community matrons whilst previous literature reports positively on the role with GPs considering that their workload had been reduced (Chapman et al. 2009). Largely positive results were also given by the GPs who participated in this study. Reservations presented were as a result of service delivery change from autonomous community matron to virtual ward model. This will be re-visited later in the discussion (section 7.3).

Community matron services in the three areas studied showed limited vision in service set up. As findings show area 1 had no operational policy until 2008, three years after the first matrons came into post. This allowed the service to develop in an *ad hoc* manner. In writing about the discipline of nursing, Graham (2010: 355) argues that: *'nurse managers need to have a clear model of nursing and its discipline firmly embedded in their thinking before they can lead anything.'* This lack of understanding around what comprises nursing in the 21st century adds to the difficulty of establishing new roles. Allowing individual matrons to develop a service in different ways, albeit around case management domains, is not helpful for establishing a well-defined new service. In evaluating consultant nurse posts and why they failed to embed, Drennan and Goodman (2011) report one reason as being able to clearly show the need for a clinical service,

such as community matrons, that was unambiguous and uncontested. As noted above, even fellow nurses failed to support the introduction of community matrons wholeheartedly. As the theme title notes, changes were often made with limited understanding of the role of community matron. The repeated mention in findings of perceived role overlap leaves the role of community matron far from uncontested and unambiguous. Benefits to patients and their carers were clearly articulated by them and will be discussed later under the person theme.

7.212 Skills and background

Backgrounds of individuals who become community matrons are varied. Many came from a district nursing background as noted above. Intermediate care backgrounds were also common. Although managers wanted to recruit from secondary care at the initiation of the role this was not forthcoming, but later appointees were more likely to have an acute background. Five appointees in role for less than 2 years at data collection point came from an acute background. In varying degrees they talked about the transition. In a paper on supporting moves from hospital working to community Drennan et al. (2005) suggested that no matter how experienced the individual was in a hospital setting they reverted to novice in a community post. Employing authorities were charged with providing mechanisms to support learning (Drennan et al. 2005). As the community matron participants who had moved from hospital came in at a later date, there was acknowledgement of education requirements, although these tended to revolve around technical skills of health assessment and non-medical prescribing. There was no formal structure to address significant difficulties of working in the community noted as:

- *'Patient is in control of all decisions*
 - *Patients and their carers undertake most of their own health maintenance, treatment and care activities*
 - *There are multiple systems and infrastructures unlike single systems in hospital*
 - *The nurse has to make decisions (clinical and professional) sometimes rapidly in less than ideal circumstances at a physical distance from professional colleagues'*
- (Drennan et al. 2005: 5)

As such, individuals who were resourceful and tenacious in their desire to be successful in the role were common personal characteristics which showed through the findings. Personality and the individual in a role rather than support for the role itself were seen as issues which affected the embedding of the consultant nurse role (Drennan and Goodman 2011). The lack of formality associated with role requirements may also be an answer as to why some community matrons who were district nurses found it more difficult to leave their former role behind. For Holt (2008: 122) role transition includes changes to self because identity as a nurse is rarely left at work but becomes an intrinsic part of the individual's personal life. A lack of vision of how the then new role of community matron would be implemented at local level into the existing health care delivery system can be seen as one factor which affected embedding of the role.

Perhaps surprisingly non community matron professional participants acknowledged the importance of broader skills. The focus was not on technical and medical skills alone, such as physical health assessment and prescribing. I use the word surprised advisedly because as part of the parent project the important factor was very much impact on hospital admissions and much of the broader and arguably softer skills employed were not of interest or valued by the steering group who oversaw the funded evaluation. It was this fact which made me decide to explore this more (Chapter 1 pg 1). That nursing is frequently seen as a biomedical activity with emphasis placed on a biotechnical world (Liaschenko 1997, Graham 2010) and the importance of showing value for money may account for the original reticence of area 1 in the parent project to accept the wide ranging skills of community matrons. I consider these wide ranging skills to incorporate the psychosocial interpersonal skills which allow the community matron to manage boundary issues in healthcare for individuals and their carers. Much of the literature on invisibility of nursing highlights the difficulties associated with portraying psychosocial aspects of care (Smith et al. 1993, Goodman 2001, Biley 2005). However, Graham (2010) notes the change in emphasis from biomedical to a health and well-being model in England. With this comes the need for a changed skill set in nursing and perhaps there is a wider acceptance of this with the former commissioners and GPs involved in the new CCGs who were participants in my study. The findings in relation to the skill set for community matrons is different from area 1 where the evaluation emphasis was on

impact of reducing hospital admissions to my subsequent investigations in areas 2 and 3. Of course, the data were collected in area 1 in 2010 and in areas 2 and 3 in 2012 may have a bearing on this change.

In addition, the visibility of community matron skills will depend on where the viewer sits within 'the landscape' (Liaschenko 1997). This is a generalisation, but we may expect doctors in hospital will view patients with LTCs in relation to medical specialisms: respiratory, cardiology, endocrine. GPs and former commissioners hold a broader overview of LTCs and consider co-morbidity. That a purposeful sample was used in this study comprising GPs and commissioners whose interest lies in the care of individuals with LTCs may have been the reason why a broader view of the importance of the community matron role was presented by them.

An important factor in successful case management is the ability to find cases. A discussion around case finding is presented next, as part of the policy (macro) theme.

7.213 Case finding

The ability to case find continues to be noted as a major difficulty by participants in my study, particularly the community matrons. This is backed up by Hall et al. (2011) who suggest that a more robust case finding tool is required. Originally the use of a national tool, PARR (King's Fund 2004) was initiated. Some trusts branched out to use BUPA Health Dialogue (BUPA 2010). Changes to both systems created problems and as noted in the findings, the development of local tools is now being considered. Even before the community matron role was devised, Wagner et al. (2002) noted a dependence on referrals rather than an active case finding approach as case management had been used in the LTC agenda in the USA. This is in line with my findings (section 6.23). However, creation of the PARR tool did attempt to address this problem, albeit not especially effectively (Billings et al. 2006). Further critique of the PARR tool was offered in the methods chapter (section 5.3).

In order to operationalise case management, there is a real need to be effective in case finding. The lack of a suitable tool is one aspect that makes the role of community matron vulnerable on two fronts. Firstly, patients who receive the community matron service would be dependent on referrers understanding the service and making

referrals, and secondly, patients who could benefit from the service but go undetected. This is shown by the matched pairs data, section 5.31) in whom presentation at hospital could be interpreted as a failure of the community matron service, as it would be known that these are patients who should be seen by a community matron, but are not. Even when the PARR tool is used it needs to be understood so that community matrons appear to be taking on appropriate patients. The impetus behind the role was for community matrons to take level 3, highly complex and fragile individuals with co morbidities. Data presented in the table of 13 patient journeys, shows that PARR scores can (and should) drop if community matron work is effective in reducing hospitalisations as the PARR tool calculates its score on past hospital admissions. Thus if the community matron is successful in stabilising the management of the individual's LTCs, the person no longer meets the service criteria and the community matron service could be withdrawn. Although reported under the theme patient, community matrons also recognise that taking individuals with lower PARR scores can offer more opportunity to work with patients before they hit ceilings for treatment. This fact needs to be understood by CCGs in order to fully understand what PARR scores mean in relation to community matron work.

Case finding, then, is a wider issue. This can be seen in international as well as national literature and is part of the policy theme (Wagner et al. 2002, King's Fund 2004). Without a robust tool, it is difficult to defend caseload size which is arbitrary and affected by referral patterns of health care professionals who may or may not understand the role of community matrons. Here again, the changes and service re-design have the potential to affect embedding as fellow professionals (and matrons themselves) lose sight of service goals. This difficulty in getting the role understood now forms part of a broad policy on integrating care.

In part, a desire for integration formed part of the rationale to address capacity issues and resulted to some changes in service delivery models. Such changes are discussed next.

7.214 Capacity and service model design

Capacity and service model changes were partly considered under the policy theme, but here are considered in relation to the organisation of care. Changes to a VW model in area 3 and inclusion of community matrons in fast response in area 2 were implemented because the initial vision was not as effective in practice as had been suggested at a national level. The key problem areas were in relation to capacity issues and limited service provision of Monday-Friday, 9am to 5pm. These aspects are commented on by community matrons who report difficulties of maintaining individuals at home when working autonomously and also the difficulty of not being able to offer a 'gold standard' service to a larger number of individuals with a LTC. What is seen here is that implementation of a new role has been achieved, but that embedding and sustaining an innovation such as the role of community matron so that it becomes a recognised and valued part of the healthcare delivery system is a complicated process which is not properly understood (Greenhalgh et al. 2004). Such changes as VW and fast response may seem like relatively small changes and yet in the NHS which is complex and unwieldy, even small changes can be challenging to manage and potentially unachievable (Walshe and Higgins 2002). Bridges et al. (2007) concur stating that the need to make changes for ongoing issues requires as much energy as at the start. This would need to include communication of change to those affected. As noted by the community matrons and GPs, this was difficult to achieve in practice.

Offredy et al. (2008b) suggest that there are steps for service re-design: process mapping, involvement of key stakeholders and visioning, service redesign, introducing the new service and implementation. In a successful re-design as described by Offredy et al. (2008b) the use of a whole systems approach where stakeholders contributed to the re-design was effective. It should be noted that this was a broader re-design than a new nursing role alone. Arguably each change has the potential to weaken the role and make it less visible, if other HCPs are not aware of the change or it does not work for them. Maben et al. (2006) noted that organisations sabotaged nurses by frequently changing aspects of their roles, albeit unintentionally which impacted on the visibility and as part of this nurses wanted to protect their roles (Smith et al. 1993) and liked a group identity to increase their visibility (Drew 2011). Building networks may be one

solution to overcome these issues. Findings in my study show that this is an aspect of work which community matrons spend a lot of time doing (section 6.27). Abell et al. (2010) suggest that informal networks need to become more formal and structured, even sharing infrastructure and joint working practices in order that they evolve. Integration of care may be seen as a means of achieving effective communication in service delivery.

7.215 Integration

That integration is a positive move in health policy which would benefit healthcare delivery systems and patients and staff at grass roots level is widely accepted, and findings across several groups of participants acknowledge the benefits (section 6.29 and 4.51). The virtual ward model may be seen as a means of exemplifying gains by merging policy themes. However in building integration the VW model arguably loses some of the proactive aspect of case management and the high level nursing skills held by a community matron.

Under the policy theme, the groups who commented most on the 'bigger picture' of integration were the managers and commissioners. For them, the complexity was in successfully creating an environment in which integration was second nature. Previous failures are noted, but it is unclear how the same mistakes can be avoided and what lessons were learned. If there has been a turnover of staff it may be possible to re-make mistakes or if the same staff remain there could be a reticence in trying again because they feel it has been tried previously. This is noted by Handy (1983) who describes values and traditions of organisations (which he refers to as tribes) holding on to stories of 'past heroes and dramas' (1993: 182) of which past failures may be considered one. Perhaps, latterly with the introduction of short term contracts in managerial positions the result could be a lack of corporate memory rather than positives and negatives of previous initiatives.

Policy including the Health and Social Care Bill (Great Britain Parliament 2012) talks about integrating care as one element in achieving quality care. Various authors (Ham and Smith 2010, Ham et al. 2011) note implementation of a policy of integration can stall. This is in line with my findings, particularly in area 2. It is suggested that more

support rather than less is required at a higher policy level (Ham and Smith 2010). For Goodwin et al. (2012) policy barriers include the payment by results approach to funding hospital admissions which mitigates against providers such as community health. This adds evidence to the findings that community matrons fight to keep individuals in their care out of hospital but this is not a shared vision, as findings support. It is possible that the new vision and model of district nursing may be a step in the direction of improving vision and creating improved integration thus benefitting patients and their carers (DH 2013). However, promoting the specialism of district nursing may also continue a culture of silo working (Thomas et al. 2008), rather than one of integration.

GPs who participated in the study were in favour of integration. Interestingly, writing in GP magazine, Sawbridge states that integrating care requires strong relationship building skills and partnership working which she considers are 'bread and butter' to nurses (Sawbridge 2011: 55). Partnership working requires equality. Liaschenko (1995)(as noted in section 3.21) notes that networks of power such as medicine can cause nursing to be silent and invisible. Debates in the mid-1990s explored the changing face of nursing with Bradshaw (1995) stating that from the 1970s American influences caused a rejection of nursing ethos which had been based on nursing as a form of altruism, as well as based on vocation. Bradshaw further contends that such breaks with past tradition has led to nursing losing its authority by rejecting submission and obedience for the new nursing values of autonomy and empowerment. For MacIntyre (1985), the loss of tradition has created a culture of emotivism which have a focus on values based on efficiency and effectiveness that is easily measurable and derived from skills; all factors which are harder to contest. The findings in my study show the dichotomy between broad holistic skills of nursing versus a desire to prove effectiveness through metrics which serve nursing poorly. Rather than a power struggle, Salvage (1995) considers that partnership is built on expert nurses such as community matrons being complementary to and not substituting expert doctors, with the result focused back onto patients and providing them with the best possible service. Similarly Lempp (1995) concurs, suggesting a clear need to focus on patient and family needs rather than disagreements over territory. As noted in section 3.2, recent literature (Fletcher et al.

2008, Drennan et al. 2011) do not highlight power as a factor in embedding new roles such as that of community matron.

In the policy theme, commissioning was explored in its broadest sense. Those GPs and former commissioners who participated discussed factors which may influence changes to the community matron service.

Integration has been discussed in relation to policy. It can also relate to healthcare delivery. What is meant by integration in the following paragraphs is the integration of different groups of healthcare professionals into a single team and may include: community matrons, district nurses, intermediate care, allied health care professionals, and psychologists. As findings note, delivery of care through integration is difficult to translate into practice.

A factor associated with integrating teams is that of professional identity. Castledine (2009) states that disciplines concentrate on their own agendas, and Parker and Glasby (2008) concur reporting a lack of integration with services operating in isolation and only communicating if required and with limited consistency. In contrast, Hudson (2007) suggests that problems anticipated and associated with professional identity have not been seen, and rather reports that they support and work well together. The findings in my study support the former literature described by Castledine and Parker and Glasby. Glendenning (2002) suggests that the following elements are some which are required for successful integration:

- Joint goals
- High level of mutual trust and respect
- Management arrangements are clear

As noted in the findings these factors are variable and maybe some reason why getting integration to work is problematic. Changes in models, such as 'step up, step down' approach whereby community matrons can move patients down to level 2 of the health and social care model and similarly district nurses can escalate patients to level 3 for case management have been suggested as ways of improving integration in the findings. This requires investment and district nurses with appropriate skills and knowledge

around long-term conditions. On a cautionary note, even up skilling may not produce the desired result. Kearney and Lever (2010) noted that skilled rehabilitation nurses' work was often invisible and Drew (2011) states that working in patient's homes can mean that the most skilled care remains invisible.

Relationships between healthcare professionals are discussed next, because successful networking is one factor which may impact successful integration.

7.216 Relationships between health care professionals

Relationships between healthcare professionals are arguably one of the most important factors in achieving a successful outcome. This has implications for an integrated service. Part of the success of building an effective relationship is the ability to communicate and to find out exactly how other HCPs can be useful in delivering that outcome. Kvamme et al. (2001) notes the importance in relation to ever more complex health systems which require more effective communication. Findings in this doctoral study highlight both positive and negative sides of communicating with other HCPs and the personal skills required to succeed in this area. Negative communication such as that which results from fragmentation can lead to harm for nurses who often seek to fill gaps. Such work is often unacknowledged and invisible (Liaschenko 1997, Goodman 2001). Conversely, De Frino (2009) considers that the positive working relationships which nurses build are a source of power which can be utilised to make nursing visible and thus embed.

In talking about the amalgamation of a community trust with an acute hospital, a manager in area 3 talks about a different language. At first she reports that despite talking to each other (community to hospital and vice versa) there was no common understanding. Wilson et al. (2007) note this as a part of silo working when a common language is lacking thereby affecting the ability to integrate services. By listening to the terminology used by acute colleagues, the community managers picked this up and started to translate similar themes and requirements within community services into this language with positive results. The use of language in nursing is a theme which appears in relation to nursing's relative invisibility with Conway (1989) noting that having no universal language does leave nursing invisible. This strategy of translating community work and framing it in 'acute' language to make aspects of the community

matron role/ VW visible, redressing any existing power imbalance is useful. As Kvamme et al. (1998) states, increasing workloads and faster turnover of patients often keep HCPs within their own subcultures. Brinkert (2010) states that conflict often arises between HCPs because of a difference of perspective and challenges faced in finding common ground. The amalgamation described as a result of Transforming Community Services (DH 2009b) has allowed some barriers to be broken down in order to provide a seamless service for patients across a traditional divide between secondary care and community. This has enabled a policy to effect speedier discharge of patients with LTCs onto the virtual ward. The awareness of the virtual ward has been increased and the role of the community matron as leader of the virtual ward is better understood in area 3. Hence it could be argued that it is more visible and as such may embed more successfully. Although this highlights factors associated with discharge rather than preventing admission, it shows how a policy of amalgamating two organisations as one has resulted in a mutual benefit to both: that discharges can be effectively managed from the acute sector and that the role of community matron via the virtual ward is a valuable asset in achieving this goal. Arguably, however, effective and well planned discharge should reduce re-admission (Bauer et al. 2009).

The findings show (section 6.22) how personality can be influential in building relationships with other health care professionals. As noted elsewhere, personality can become more important than the role itself. Drennan and Goodman (2011) discussing consultant nurse roles contend that particular attributes of the individual post holder are more important than the post. Communication between key players is therefore likely to be strong and a key skill of the individual. Handy (1993) would explain this in terms of a person culture in the organisation exhibiting expert power through doing what the individual is good at and as a result notice is taken of their opinions.

How different grades of staff have been introduced as part of service model change and implications of this change are discussed next.

Much of what community matrons say (section 6.22) in describing their work shows skills built on experience and confidence in their own abilities. As Manley (2005) expresses, nursing expertise is associated with specific characteristics shown through

professionally artistry. The powerful case examples, from data in my study, show that patients (and their family carers) are very much at the centre of their work. As Sutton and Smith (1995:1040) contend, this makes advanced practitioners such as community matrons willing to 'bend rules' in order to achieve the best outcome. This is often work that is invisible to management, because it may not fit traditional organisational guidelines. For Benner (1984), this makes community matrons expert, however, I argue that it makes some community matrons experts, because not all exhibit the same level of skill. Other factors such as previous background and experience, education offered and even personality makes some proficient in taking on additional skills to become expert. The introduction of skill mix has met with complaints from community matrons of their role being 'watered down'. GP participants in this study suggested that there were aspects of the role which could be undertaken by someone else of lower grade, but in so doing this could also extend the scope of the service.

As noted in findings linked to the virtual ward, GPs had concerns in relation to skills exhibited by some staff in the VW. Strong leadership is required and perhaps an overhaul of district nursing which as the Queen's Nursing Institute (2012: 21) notes: *district nurses are the only professionals with no limit to their workload.* For community matrons to effectively case manage they do require support from other health care professionals and agencies. Randall et al. (2011b) report on one such project where lower grade trained staff took on an in-reach role (so a role which actively sought to follow patient progress if they were admitted to hospital) which encompassed some components of case management and could be seen as a 'cheaper alternative'.

Conclusions drawn included the benefit of a wider range of nurses having an understanding of a whole systems approach ultimately benefitting the quality of patient care. In Benner (1984) terms, we may consider skill mix in terms of individuals who are novice, advanced beginners or competent. At whatever stage, additional education is required and the community matron is ideally placed to offer clinical leadership providing that the change in service delivery has not allowed the role to become mired in management issues and reduced clinical contact.

7.217 Hospital Admissions

Although, generally speaking patients and carers who participated did not comment on changes in service or skill mix, Mary was aware and knew that if her husband seemed to have a chest infection she needed to be visited by a nurse with appropriate skills and always asked for someone with a stethoscope (section 6.25). This would ensure timely treatment and prevention of a hospital admission if possible. This is positive as it shows carers having a voice which Williams (2007, 2012) notes is rare as they are often seen as a nuisance.

Community matrons, through case management, were expected to reduce hospital admissions in patients with long-term conditions (DH 2005a). This is discussed as part of policy but should also be considered in light of patient and person. As such, this was a metric used by commissioners in many areas (notably area 1 in my study). This is in line with MacIntyre's (1985) suggestion that emotivism concentrates on measurable effectiveness which here is the ability and effectiveness of community matrons to keep patients out of hospital. Results and findings were mixed on this point. As noted in section 6.53 in table 23, patients who had been interviewed and then were followed up using PARR data showed a reduction in hospitalisations after being case managed by a community matron. This was in line with their views when asked about hospitalisation in their interviews. This led to a bigger sample (n=212) being examined, half who received the intervention (case management by a community matron) and half in a comparison group. By exploring a larger data set it was hoped that analysis would show that community matron intervention would have a statistically significant effect on hospital bed days when compared with an independent sample of individuals with LTCs. The only significant result was seen when examining hospital days between medium and high risk patients in the comparison group ($p=.040$). However, there is a danger of 'chasing' significant p-values and the significance here is relatively weak. No clear explanation emerges other than to highlight that measuring community matrons on hospital admissions is too narrow a metric which fails to capture the complexity of the work undertaken by community matrons and the complex nature of living with co-morbidities.

Indeed, Roland et al. (2005) examined hospital admissions over a 5 year period and found that there was a fall in the high risk group in relation to both hospital bed days and admissions without any intervention. Iliffe (2006) concludes that monitoring hospital admissions is not a good enough metric on which to judge case management and in this case, I contend, the community matron role. As highlighted elsewhere, the wealth of evidence provided in qualitative interviews about saved admissions underpinned the research design of my thesis (QUAL/quan). The debates around merits of quantitative methodologies and qualitative methodologies and the wisdom of combining them were addressed in chapter 2. That randomised controlled trials remain the 'gold standard' (Mazurek and Fineout-Overholt 2005) is clear. Yet, this is contested by many writers, with Bradley and Field (1995) acknowledging that not all that is measurable is of value and not all that is of value is measurable. RCT was not an option open to me, so matched samples were used as discussed in section 5.31. Indeed, Lord Darzi stated that the effectiveness of care should be measured both in relation to clinical measures but also patient report (DH 2008a).

The policy emphasis at national level of holding patients at the centre of decision making also led to a focus on patients as evaluators of care. However, Staniszewka and Henderson (2005) warn that patient report is widely encouraged without any real understanding of patient satisfaction and what HCPs are attempting to measure. In a study of patients, Staniszewska and Henderson found that the vast majority of patient satisfaction surveys were positive and that there seemed to be a normative effect which inhibited criticism. Various factors influenced patients such as gratitude, faith and loyalty, but also their sense of engagement with their healthcare. I consider this mirrors many of the findings presented in this study. Patients were also good at making allowances for the limitations of the NHS. Such issues should be considered when making patient report a metric which is then used to evaluate a service such as that of community matrons.

So, interpretation of policy from the Department of Health led to the implementation of the community matron role. The findings and results discussed offer some explanation in relation to the objective considering how role and service design has been embedded

in light of policy initiatives and the emphasis on reduction in admissions to hospital. With difficulty finding a suitable metric to consider impact of the role, the vast array of work undertaken by community matrons may be invisible to new clinical commissioning groups. Prior experience of the community matron service by CCGs may also be a factor. The commissioning role is discussed next.

7.218 Commissioning

The GPs interviewed all had specialist interests in relation to long-term conditions. It was this interest which led them to become part of the new CCGs. Dichotomised views were expressed in relation to the new GP role. On a general level, they reported colleagues being keen or horrified whilst on a personal level they talked of personal cost in relation to the expanded role versus wishing to make a difference and continuing to be patient advocate whilst holding the 'purse strings'. As a fellow GP writes in an article: *'It feels pretty remarkable- as well as quite scary to have been delegated budgets totalling £720 million'* (Moorhead 2012: 4).

In line with current drivers, all GPs noted the need for services to be more integrated in relation to LTCs and all saw a need for community matrons within that vision. The value of the service provided by community matrons has been seen by the GPs interviewed for this study. How the service would look in the future is not certain but the GPs in area 3 felt it would follow the VW model as a result of CCG decisions around commissioning. This service delivery model appears to be more visible and likely to embed. It may be possible that the reasons for this are the close synergy of VW to a medical ward and thus closeness to the biomedical model which protects the medical profession's power base. So although the VW is more visible, it is not nursing or the community matron role that is necessarily visible within this.

7.219 Summary: policy, visibility and embedding

In this section, I have discussed many factors which can be seen to have an influence on the visibility of the role of community matron. The interpretation of policy here in relation to the long-term condition agenda, hospital admissions, case finding, capacity, integration and commissioning could be seen to affect the embedding of the community matron role. That the role should change in line with policies on integration is broadly welcomed in the findings. However, at this level the community matrons themselves

have a limited say and can be at risk from changes in centralised policies. Aspects in this section (skills and background, case finding, health care professional relationships and joint visits) have contributed to examining the objective of how the role of community matron has been operationalised through case management. Role implementation and capacity and service delivery models, has in part, considered the objective: embedding in the light of policy initiatives and the emphasis on reduction in hospital admissions. Other aspects explored under this theme (role implementation, case finding, capacity and service delivery models, grade of staff and changes to commissioning) have offered a community matron viewpoint of these as factors which have had an impact on embedding of their role in line with the objective.

In summary, these factors comprise:

- A national idea implemented pragmatically at local level and on occasions different interpretations within one health trust arguably making the role less understood and visible.
- Reduction in emphasis on the domains of case management framework may have led to a less focussed means of explain the role to HCPs, thus decreasing visibility.
- Poor operational policies leading to accusations of role ambiguity show that the role of community matron is not as visible as it could be.
- How visible the role of community matron is may depend on the view point of the viewer.
- Inadequate case finding tools leaves the role vulnerable to not being seen.
- Constant service re-design, however well intentioned, leads to confusion for HCPs who refer, which requires significant time and effort to communicate changes so that the role is not lost.
- A positive outcome from policy amalgamating a community and acute trust is noted to have increased visibility of community matrons, but through a VW model which is arguably in line with a medical view point.

- Increased skill mix may have altered the emphasis of the community matron role from case management to managerial thus reducing visibility of the advanced skills held by matrons.
- The use of reducing hospital admissions as a key metric on which to evaluate community matrons makes other aspects of the role less visible.

All of these factors are likely to compound the difficulty of embedding the role of community matron as a valued, recognised and effective means of managing individuals with complex co-morbid LTCs.

Interpretation and discussion of the first theme, policy has been presented and now, I move to explore the theme: patient.

7.3 Patient (meso)

7.31 *'A little bit of extra effort': delivery of healthcare by community matrons*

For Liaschenko (1999), there is a bridge of social knowledge comprising knowledge in relation to other health care professionals, the organisation of care and finding the most appropriate person to provide care. This first bridge sits between case and patient, so in my thesis this bridge sits between policy and patient. The bridge allows consideration of social knowledge in relation to other health care professionals, organisation of care and finding the most appropriate person to manage care. Patient knowledge was seen as represented by how individuals were identified as patients, the response by individuals to therapeutics, knowledge of how to get things done and knowledge of other providers. The first social knowledge bridge I consider is represented by the use of joint visits by community matrons. This represents how the right HCP is found to manage the patient and is discussed next.

7.311 Joint visits

The use of joint visits was mentioned by community matrons, particularly utilising the skills of specialist nurses, but also on occasions, mental health colleagues and less frequently social services. GPs reported offering to do joint visits as a means of increasing learning, but that there was limited uptake. If community nurses (including matrons) had a 'political outlook' they may consider the advantages of taking up such

offers, which could in turn help them increase the visibility of the service and role with GPs who have a direct influence on the commissioning of services. Drennan et al. (2011) re-iterate this stating that engagement with a breadth of stakeholders is required to ensure expertise is recognised. There may be various impediments which surround the uptake and frequency of joint visits. Firstly, if specialist nurses hold caseloads this may make them busy and not in a position to undertake joint visits with community matrons. Basset (2006) contends that it may be right for specialist nurses to step back and act as a resource for community matrons who will actually plan care. Lyndon (2006) felt that there was a potential for tension between specialist nurses and community matrons but that acting as a link to community matrons, the specialist nurses could provide support to more patients in need. The RCN (2010) states that every patient with a LTC should be able to access a specialist nurse as a right. Secondly, individual workers such as community matrons or skill mix staff need to have the personal confidence and organisational support to feel able to say when they need help. Every nurse cannot hold every piece of information and therefore sharing knowledge is important to ensure that patients with LTCs receive the best care from the most appropriate individual.

The knowledge which Liaschenko and Fisher (1999) associate with their interpretation of patient includes knowledge of how an individual is identified as a patient, how the individual responds to therapeutics, a knowledge of how to get things done and lastly knowledge of other providers. Analysis of the qualitative data provided by participants gave me concepts which I have chosen to group under the umbrella term 'patient' (meso). These concepts form a part of the theme: delivery of healthcare and are defined in appendix 9. They include health promotion, communication, medication, leadership and management, telehealth and end of life care. The findings presented as part of this theme matched in many areas. A wider interpretation and discussion is now offered, starting with some general comments about my study and community working.

For the community matrons in area 1, a major anxiety was how to record and receive acknowledgement for their work and how outcomes were achieved. This anxiety was mirrored in areas 2 and 3, but because participants volunteered to participate in my PhD

study rather than volunteered as part of their service being evaluated may be a factor too. This does not invalidate the seriousness of the issue, however.

Sutton and Smith (1995) consider that nurses who work in less technical areas, such as community matrons working in patients' homes experience difficulty in having their work seen and known by others. This point is mirrored by Kearney and Lever (2010) and Drew (2011). The ideas mooted by Sutton and Smith were published in the same year as Liaschenko's empirical work. Though 17 years ago, community matrons' still exhibit difficulties in having the intricate and multi layered work they do, seen and acknowledged by others. There may be a rhetoric in terms of language used: self-management and holism are two examples used frequently by non-matron professional participants (GPs, managers, former commissioners), but the time to achieve these facets of care still appears to be underestimated. In this chapter I now move on to consider some aspects of health care delivery, beginning with aspects around health promotion.

7.312 Health promotion

Health promotion was an aspect of case management enjoyed by some community matrons and found difficult by others. Findings on this subject led me to consider that background of the community matron was quite important here. As noted previously, a community matron who had formerly worked as a practice nurse had more experience in health promotion than another community matron from an acute background. The former can perhaps be considered to understand the shift in health care paradigms. As Graham (2010) states, the focus of health care in the 21st century should be on health promotion and wellbeing and a movement away from the biomedical model of diagnosis and treatment. Of course, dismissing the latter entirely is not appropriate and community matrons are trained to hold skills dear to the biomedical model in terms of health assessment and non-medical prescribing, but that these skills sit as part of a much broader remit more in line with the biopsychosocial model is important. In a hospital setting it remains more common for individuals to be passive recipients of care whilst power and authority remains with health care professionals (Daly and Roebuck 2008). As Trish describes in her comments (section 6.41), in hospital she was able to influence what someone ate which was not the case in visiting someone in their own

home. This is just one of the challenges, as noted by Drennan et al. (2005) that patients are in charge in their own homes.

Additionally cultural differences were acknowledged by matrons showing another facet of care which is important in successfully working in partnership with individuals. This is part of 'person' and will directly affect health outcomes. The importance of raising issues around promoting health is seen as important to patients. Harry notes an expectation that this will be done (section 6.31), and sees a value in the advice, not least because it sends out a message that his wellbeing is important. That someone has a long-term condition or multiple co-morbidities does not preclude the need to promote health which may maintain or prevent another aspect of ill health.

7.313 Communication

When broaching issues around health promotion, the approach taken is important and is one part of the high level communication skills required to undertake the role of community matron. The community matrons report the 'highs and lows' of communication particularly within their audio diaries. Attempting to establish effective communication can be an emotional drain as noted by Veronica (section 6.32). As lynchpin, the community matron pulls together and re-distributes the information. In Lauren's example of communicating with a consultant because the patient lacks confidence or ability to do so, this could be argued to be a paternalistic action. The focus would be better to empower the patient to take control and pass on the relevant information. However, there are many factors which we may not be aware of in what is presented as a snapshot. From one point of view, the community matron action is quite likely to prevent further ill health and admission to hospital. As Boddenheimer et al. (2002) emphasise, patients are experts about their lives, but HCPs are experts about diseases and this offers an explanation for the community matron action which does not mean that she is not employing a partnership approach.

Paul relays an experience of communication where the community matron acts to pull lots of strands together ensuring that he (and his wife) have the facts (section 6.41). The importance to him is clear. As Stanizewska and Henderson (2005) describe, being engaged with a health care professional has a positive effect on the experience.

Engaging patients with their medication is another area in which community matrons invest considerable time and effort. This is discussed next.

7.314 Medication

Almost all of the community matrons and indeed patients and carers who were interviewed spoke about their medication and in particular the usefulness of blister packs. Blister packs were noted to improve clarity for patients of what to take and when, thereby improving concordance and independence. Manias (2010) states the importance of communicating about medication which promotes patient safety, quality of care and patient and family engagement.

An area highlighted as problematic in relation to communication around medication is the gap in communication between primary and secondary care (Ahmed and Harding 2005). In data provided by the community matrons, the biggest issue here was that patients were not discharged with blister packs. In one case, this apparently simple omission left a patient without medication because their carer (from a care agency rather than a family carer) was not able to dispense it. The community matron is the health care professional who steps in to resolve the problem. Similarly the community matron is ideally placed to identify when patients, for whom English is not their first language, are taking the wrong medication. The consequences of taking the wrong medication are potentially fatal. At a time when saving money and cost effectiveness are high on the political agenda the community matron is contributing to a potential saving of between 15% and 25% of total hospital care as a result of poor communication around medicines (Institute of Medicine 2006). This 'extra effort' as noted in the theme title is frequently noted in the delivery of care by community matrons.

The ability to prescribe is described by one matron as making the process much leaner and indeed patients really appreciate the speediness with which treatment can be started. However lack of experience in prescribing in relation to very complex health needs is noted as an area where improvement is needed according to GPs. This was a comment in relation to the virtual ward rather than community matron. The change in service delivery model could be seen as weakening the community matron role in

relation to prescribing although undoubtedly offering benefits in other areas as mentioned previously.

7.315 Leadership and management

As part of the sub theme of delivering care, I have chosen to include issues around leadership and management largely because of how these aspects of the role affect individuals. Leading is mentioned twice in the domains of case management (NHS Modernisation Agency 2005 [section 1.16]) firstly in relation to leading care coordination and secondly, domain F is professional practice and leadership. In the findings section, I present data from individual areas, because there are differences. Probably the biggest differences are in relation to service delivery model and particularly the virtual ward and then the use of the term clinical leadership. At this point, I think it is important to re-visit the reason for roles such as community matron. Historically, gaining promotion in nursing took nurses into education or management (Davies 1995). Career pathways were developed which would keep senior nurses with a clinical focus (Burton et al. 2008 and Drennan and Goodman 2011) hence the role of community matron was devised as an autonomous role with no responsibility for man management. This was entirely the reason that Lucy wanted to be a community matron and Miranda, one of the managers who set up the service in area 3 was clear that man management was not part of the community matron role.

In area 3, where the virtual ward was introduced, findings show just how much of the community matron role has been sidetracked from a purely clinical focus to managing staff, rotas, and human resource issues. As Stanley (2006) explains, nurses do not always make the best managers and when in managerial posts can still be expected to maintain clinical responsibilities thus making the burden greater. This led one community matron to state she was becoming de-skilled as a result of less and less time spent with patients. There has been a large investment in each community matron to up skill in 'medical' skills such as health assessment and prescribing, and these skills take time to embed and develop as pointed out by Lyn, one of the GP participants who notes the differing skill level in more junior staff or staff with less experience. Other managers in areas 2 and 3 justified some of the new aspects of the community matron role in terms of clinical management. The justification appears to have parallels between a ward manager role

in hospital whereby managing rather than being clinically driven is a focus which arguably takes away from patient care and nursing model to a medically focussed operation. Similarly, Drennan and Goodman (2011) report consultant nurses experiencing similar difficulties. While their managers were emphatic that the role of consultant nurse was not a managerial role the boundaries between clinical leadership, service development and management was not transparent either conceptually or practically. The use of the term clinical leadership by managers may be considered expedient. As Lewis Carroll suggests: *'when [you] use a word...it means just what [you] choose it to mean-neither more nor less'* (Carroll 1872, chapter 6). It is clearly a source of deep frustration for many of the matrons who participated in my study.

Indeed, a Department of Health report into district nursing in 1992, is suggested as the reason why senior DNs become managers rather than being valued for their knowledge in relation to patients (QNI 2012). One community matron makes this demarcation in trying to establish role boundaries: DNs manage, community matrons are clinical leaders. Although an attempt to provide clarity in relation to roles and responsibilities the complicated layers and levels of management and leadership do little to promote the idea of a coherent and integrated service, rather one that is trying not to duplicate and 'stand on the toes' of others. Not only are leadership and management confused, but adding in the term clinical leadership adds another dimension to the mire. Findings would suggest that changes in this area have been unsettling to the community matrons and may have affected the embedding of the role.

New ways of effectively managing individuals with long-term conditions are continually being sought. One such initiative is that of telehealth and this is considered next.

7.316 Telehealth

Many patients who have been introduced to telehealth have positive views on the benefits of such a service. One such patient, who took part in the 'Whole System Demonstrator Project' (WSD)– a two year RCT stated:

'A year ago my blood pressure was fluctuating a lot, it was on the higher side. I received a call from the telehealth nurse to call an ambulance or go to the hospital immediately...I called the ambulance. I'd had a minor stroke. I'd say that my life was saved because of telehealth.' (Ahmed Rizwan in Awang and Ward 2011:183)

Despite a lot of evidence of this nature, this was contrary to that reported in the findings of my study where a community matron reports patients being hard to engage.

However, commenting on significant barriers in the 'Whole Systems Demonstrator' (WSD) project, Johnson (2009) notes those which affected service users included levels of social support, issues of trust and personal practices. Findings in my study report high levels of trust with community matrons (section 6.41). However they may not be the only professional group working with patients on this WSD project. As the reader may remember issues of trust were key in this study gaining ethical approval. The approach to patients and carers had to come from the community matron as a trusted individual and not from the researcher (a stranger) contacting people who are perceived as vulnerable.

Headline findings from the WSD project included a 20% reduction in emergency hospital admissions and 14% reduction in bed days (DH 2011b). One community matron who commented on telehealth did not feel that admissions to hospital had been reduced. The project roll out in area 2 was still in its infancy, however. Johnson (2009) further notes that other barriers to the WSD project included skills and attitudes of staff and their perceived capacity to take on another role albeit one that Liane in this study felt had impacted her workload in a positive way. The introduction of telehealth through national policy and then service design at the 'patient' level shows how this could be utilised by community matrons and hence is in line with the research objective which considers reduction in hospital admissions.

As there is a domain of practice around end of life care, community matron participants were directly asked about their role. What follows is an interpretation of the findings associated with end of life care.

7.317 End of life

The findings in my study in relation to end of life care for individuals who have long-term conditions highlight differences to those individuals who die from cancer. This is in line with literature. Bern-Klug (2004) uses the term: 'ambiguous dying syndrome', whilst Coventry et al. (2005) call the death trajectory of individuals with LTCs 'entry-re-entry'. Patients and families tend to become used to exacerbations and then recovery, albeit at

less functioning than prior to the exacerbation. Despite frequency of exacerbations increasing as the disease progresses, it must be natural based on previous experience, to expect to recover. Liane mentions the importance of supportive care, which often requires active management of symptoms towards end of life (section 6.36). Inability to control symptoms is noted as a main reason why a large proportion of deaths occur in hospital (Abel et al. 2009). This is despite the fact that most individuals report that they wish to be at home to die (Clark and Seymour 1999). Although, Munday et al. (2009) found that it was not uncommon for patients to change their mind about place of death.

Another issue which was highlighted by community matron participants was the myriad of services available for patients at end of life and that sometimes this could create confusion as to who was leading and who was responsible for what. Again, dealing with complex situations and juggling numerous commitments is often unacknowledged and potentially leads to emotional distress (Paterson et al. 2009). Faulkener (1998) reported similar issues in palliative care where there were difficulties in defining roles and boundaries.

The uncertainty which surrounds the actual end of life phase can make this a difficult case management domain for community matrons. However policies which have been put in place: End of Life Strategy (DH 2008c), Liverpool Care Pathway (Ellershaw and Wilkinson 2003), Preferred Priorities for Care and Gold Standards Framework (National Gold Standards Framework Centre 2008) can all be used with patients who have a LTC and so clearer guidelines help all those involved including community matrons. Still needed however, is clear communication about which role is being undertaken by which HCP and a coordinator role such as that of matron may still be a useful addition.

7.318 Summary: person, invisibility and embedding

In summarising this theme, I consider that the elements presented match Liaschenko's bridge of social knowledge between the macro level of policy and the meso level of patient by considering findings in relation to organisation of care, how to get things done and knowledge of other providers. There is also a direct link to Liaschenko's 'patient example'. A lot of the factors highlighted have shown the difficulties of making a role such as community matron visible and how this affects embedding. In particular, this

theme has presented findings which, in part, meet the objective of operationalising case management (health promotion, communication, leadership and management and end of life) and medication as an issue which is a valued aspect of the community matron role from the perspective of other study participants. In summary, the factors presented comprise:

- A lack of political expediency, such as using joint visits with other HCPs, to increase knowledge of the specific contribution of the community matron thus increasing recognition and visibility.
- Difficulties in recording the nature of work undertaken can impact on what is seen by other HCPs.
- Partnership working which accepts patient choice to make unwise decisions may mean that the work of community matrons is questioned in relation to effectiveness.
- Less effective prescribing as a result of skill mix may increase visibility but for the wrong reasons.
- Acting as team manager means the community matron role is seen as managerial rather than patient facing.
- End of life care involves an array of services which may leave the community matron role invisible in this aspect of care.

These factors affect to what degree the role of community matron is seen. If the role is not visible it is at risk of constant change which affects embedding.

Discussion around the role of community matron will be further explored on the micro level of person which forms the final theme.

7.4 Person (micro)

The discussion now explores how I consider that the final 3 themes: psychosocial aspects of living with a LTC, patient journey and invisibility of community matron work appear to fit with Liaschenko and Fisher's ideas of person which could also be termed micro level factors. For me, this explores how knowledge of person allows the individual living with a long-term condition and their family to be held at the centre of care. As noted earlier, I also use this theme to discuss the impact of working with this client group on health care

professionals and in particular the community matrons themselves. For Liaschenko (1999), the concept of person relates to knowledge about personal biography. It also links patient and person through social knowledge which Liaschenko defines as knowledge beyond the boundaries of healthcare. In so doing the discussion will show how many of the findings presented impact on patients and carers, but especially on community matrons in a way which is not well documented. Some of the issues presented will illustrate work by community matrons which is boundary work and may be considered beyond the limit of healthcare.

I start by presenting an interpretation of findings associated with psychosocial aspects of living with an LTC. Definitions can be found in appendix 9.

7.41 ‘Climbing Mount Everest’: psychosocial aspects of living with a LTC

Undoubtedly gaining timely and effective treatment is important to patients and carers who live with long-term conditions, but in addition to the physical needs associated with illness the findings of my study show that other aspects including the psychosocial aspects of living are as important. For me, these include support, enabling mental wellbeing and advocacy (sections 6.41, 6.42 and 6.44). These are elements of care highlighted by other authors who have examined the role of community matron (Challis et al. 2011, Williams et al. 2011).

7.411 Support

I think it is unlikely that many people would not appreciate support. The support offered by a community matron is almost universally welcomed in my findings, as in the broader literature, although Ava did provide a moderately counter case begrudgingly acknowledging the support she received (section 6.41). Why findings are positive in this respect is considered in the study limitations. Support is noted through strength of relationships which are built on trust, reduce stress, allow additional care and comfort and consider the patient as a whole (Lyn’s comments on the patient MOT, section 6.41).

Carers particularly value their inclusion by community matrons. As Meleis (2010) states in relation to nursing rather than specifically to community matrons:

'a patient cannot be effectively considered as an isolated unit but changes in his condition must be explored and considered in terms of his relationships in a network of significant others.' (Meleis 2010:18)

Certainly community matrons are inclusive in their care of significant others. This is noted as rare by Williams 2012, although her work largely focuses on care in an acute hospital rather than a community setting. That support is available following hospital discharge was an important issue to patients who participated in a study by Wiles (1997). The support highlighted was not only in relation to knowledge but also that nurses should have social and emotional skills as well. Further Staniszewska and Henderson (2005) found that patients needed support when they were frightened and required support to maintain their dignity. Such factors increased engagement and are a part of more than the care of the physical being. Making psychological care visible remains a challenge (Biley 2005). Closely linked to support is mental well-being and this is discussed next.

7.412 Mental wellbeing

Findings were interesting in relation to the domain of managing cognitive impairment and mental wellbeing with community matrons seemingly very anxious to stress that they were inappropriately trained. Two things occur to me. Firstly, some matrons did make a distinction between managing individuals with cognitive impairment and those suffering from acute mental illness. The latter does not form part of the domains of case management and it is likely that unless specially trained the majority of health care professionals would need to seek additional specialist help to manage acute mental crisis. Their apparent discomfort with cognitive impairment is perhaps more surprising. When challenged they did report seeking specialist help as they would with complex situations in COPD or heart failure, but this did not seem to lessen their anxieties around this area.

In making a demarcation between an illness such as dementia and more general mental well-being there was evidence in the findings which support the work undertaken by community matrons. One matron talks directly about 'handholding' whilst others mention this support in slightly more abstract ways. Arguably this could be seen as an expensive resource. Agnew (2005) reports an NHS moderniser suggesting that if people are lonely they should be given a dog for company as this is not a nursing need but

rather care. In my view this is not looking at the individual as a whole. The literature encourages me that talking to patients acts as a form of debriefing which can promote transition in health status, in expectations or in abilities (Meleis 1991). In so doing, community matrons are encouraging patients to work in partnership, to engage in understanding their illness and to increase their ability to self-manage and be as independent as possible. Nursing therapeutics such as promotion, prevention and intervention are noted by Meleis (1986) as a means of improving both emotional and physical well-being and therefore increasing the likelihood of successful transition. DeFrino (2009) contends that when a nurse is friendly or chatty, this is more than about being nice, but rather about skill to create rapport and partnership in the patient- nurse relationship. Gaining knowledge about the person will enable the nurse to achieve better outcomes for the individual (DeFrino 2009). Graham (2010) argues that the real experiences of nursing are found in person to person contact which enables nursing to be seen as *'the science of knowing people and their needs.'*(358). Link this to Liaschenko and the importance of person and the community matron role seems to offer a strong affinity to this view of nursing and what nursing is about. Strong leadership is required to get these messages across to reaffirm why roles such as that of community matron are important for patients but also for nursing as a whole. How to show this work is not clear and therefore perpetuates the invisibility of many aspects of community matron work.

Other aspects of care mentioned by patients and carers included the community matron having the time and capacity to have a laugh and joke with them. Help to gain respite care was something which carers said made a very real difference to them. This may be considered boundary work. Organising respite care is a social services role but here community matrons are acting as a bridge. 'Climbing Mount Everest' showed the enormity of the task for a carer and the support benefits and impact on mental wellbeing for a carer through the intervention of a community matron. The issue of boundary work will be discussed further in relation to emotional impact on community matrons.

7.413 Advocacy

I chose to include advocacy as part of psychosocial support. My rationale was in light of participant comments on their work. The work portrayed had links which were more to do with social issues which in turn could be argued to impact on mental wellbeing. Indeed the different perspectives presented resonate with Boddenheimer et al.'s (2002) work and the community matrons understand that sometimes there is a need to advocate for patients on other matters which once sorted out will allow them the peace of mind to explore health issues. This is also in line with findings from McIlpatrick et al. (2007) who argue that nurses need to focus on the 'here and now' concerns of patients rather than the biomedical perspective alone. However, Wilson et al. (2012) contend that the preferences and expectations of patients in relation to management of chronic disease were framed by a biomedical view. The responses from participants in my study do not have a biomedical emphasis, but different methodologies between studies may be a factor.

Acting as advocate can place community matrons in conflict with other HCPs. Again whose role it might be to undertake what I define as boundary issues may be partly to blame for such conflict. There are many findings which report a positive outcome however which Brinkert (2010) suggests allows power and relationship issues to be explored and surfaced.

Part of the exploration of power and relationships is not just reported in relation to other HCPs and agencies but also in regard to patients. One powerful example of advocacy was presented by Jess and explores acting as advocate for a patient which involves very real risk (section 6.44). Roebuck (2011) examines risk which may lead to litigation as perceived by an organisation, against policy drivers which seek to allow individuals to live their lives to the full. That a community matron is prepared to work with an individual to explore such major decisions offers an example of true patient advocacy requiring time, and effective negotiation and communication skills to name just some. How such outcomes are recorded is again difficult to see and the extent of the community matron role difficult to show. This is in line with much of the literature on invisibility and nursing and particularly documentation of work (Kearney and Lever 2010). Indeed, Goodman's (2001) comments about balancing work and divergence from

the interests of medicine are perhaps central when advocacy is undertaken. This is undoubtedly an example of care directly related to quality of life but as Graham (2010) contends, is this really valued or understood? (pp358).

7.414 Non adjustment

As part of the psychosocial sub theme, I consider aspects related to non-adjustment. There is acknowledgement from community matron participants that some individuals like the sick role and find it hard to adapt to changes associated with having a LTC. Some community matrons report working with these individuals in an attempt to make a difference, but admitting failure in some cases. With such individuals, the use of psychology services may be of benefit, because the sick role almost certainly is an expression of deeper issues. There is awareness that psychology services are limited, but Lord Darzi highlighted the need for improvement (DH 2008a). This is an area mentioned by one of the GPs who sits on the newly formed CCG. Considering patient need outside of the physical need may be a positive step in seeing patients as a whole and having greater impact on managing individuals with LTCs.

Successfully developing autonomy and coping in patients is a large part of the community matron work. It requires recognition of the person which considers the factors which are important in their lives and how these factors can be used to motivate them to change. Again, the findings show many aspects of this role. Recording these in any meaningful way is difficult hence reducing the visibility of the role of community matron.

In particular, this theme has addressed aspects of the objectives: operationalising case management (mental wellbeing) and the third objective which sought to explore aspects of the community matron role which are valued (support, mental wellbeing and advocacy)

7.42 'A jigsaw of care': patient journey

Further exploration of self-management is offered as part of the patient journey theme which is interpreted next. Additional areas considered include: out of hours issues, care coordination and referrals and discharge as it relates to hospital and also from CM/VW caseload. Definitions are offered in appendix 9.

7.421 Out of hours

Changes to service delivery models in areas 2 and 3 which lead to a 7 day a week service with extended hours was noted as having an impact on reducing out of hours admissions according to community matron participants. The greater difficulties associated with out of hours in area 1 could be because the data was collected in 2010. Although out of hours doctors are mentioned, calling 999 is also described by community matrons, and not least in relation to end of life. The West Midlands end of life care clinical pathways group (2009) found that increasing working hours by an enhanced primary care team, improved integration and coordination across health and social care and education could make a difference. Pettifer and Bronnert (2013) states that as major providers of out of hours care, the ambulance service could benefit from the recommendations. This could result in improved relationships between community matrons and the ambulance service.

Findings from community matrons in areas 2 and 3 suggest that changes in service delivery have gone some way to reducing out of hours difficulties for patients and carers. As described above, patients are generally reluctant to go to hospital because of the inevitability of something going wrong in acute care (Williams 2004). Community matrons describe situations where admission is necessary, however. Increased communication across all sectors and a flagging system of those individuals on a community matron caseload is something being examined in all areas in an attempt to provide a more integrated, coordinated and effective approach to maintaining individuals in their own homes whenever possible.

Part and parcel of effective communication between HCPs is the impact on both care coordination and referrals, and is explored next.

7.422 Care coordination and referrals

The ability to refer to other agencies, especially third sector agencies is reported as valuable to community matrons and to patients and their family carers. Part of this is about knowledge of the person and through that in depth knowledge being able to find agencies that can help with specific difficulties. Referral also forms a part of care coordination. Here the knowledge of person also includes wider family needs which are affected because of the complex nature of some people's health requirements. This is

beneficial to the individual living with a LTC who is likely to have improved physical and psychological wellbeing as a result of positive family relationships (Frude 2010). Wright and Leahey (2000) stress the importance of illness being considered a family affair as explored in the findings, and acknowledge that family carers are at risk of burnout. The examples of care coordination presented show how community matrons work on behalf of the patient but also their family, coordinating with other agencies so that The Carers Strategy (DH 2008d) can be enacted.

The examples give insight into the length of time which can be involved in relation to coordinating care and the lengths that community matrons go to on behalf of patients on their caseload. However, Isobel's case (section 6.52) also highlights a family that have been hidden for a number of years from appropriate help and services. This raises questions about how many other families exist in similar circumstances and would benefit from a community matron. This links with the quantitative aspect of the study where 106 individuals were matched in three criteria and yet did not have the services of a community matron leading to the assumption that there is a hidden population. Julia's comments about inequity of providing a gold standard service to a minority ring true. These factors also link to the poor case finding ability, but in turn may lead to further capacity issues even though increased hours and team working have been introduced. Pulling all these factors together may actually make it very timely to re-configure district nursing back to its roots of proactive rather being a reactive service in order to address policy drivers, healthcare delivery and also patient and carer needs in relation to long-term conditions. As Glasgow et al. (2001) state, chronic care requires a proactive, planned, patient oriented and longitudinal approach. Arguably these are ideals that are promoted by care at home and therefore placing community matrons and district nurses at the forefront of leading and successfully achieving these outcomes.

Referrals and care coordination stretch across a breadth of services. Some sit within health care, others outside such as social services whilst other links to third sector organisations are also important in establishing a whole package of care for individuals with long-term conditions. Often patients are treated by several care providers at the same time (Berendsen et al. 2009). Assessment and care management improved

coordination when led by one person (Christiansen and Roberts 2005). The usefulness, then of having one role to pull all these strands together makes the role of community matron important.

One matron uses the term 'lynchpin' in relation to the role of community matron, as noted by Randall (2011). A common understanding of the role of coordinator within health care would make the job of community matrons easier and it could be argued that a strong partnership approach would also improve the working lives of other agencies and HCPs too. Care coordination and referral to other services in order to benefit patients is key in operationalising a central domain of case management. Interview and audio diary findings are littered with valuable examples of this element of the community matron daily work and yet even in my classroom, nurses from the acute sector continue to have limited knowledge of this valuable role and how it can help with coordinating onward care following discharge. The role of community matron continues to have limited visibility. Kelleher (2003) described how continuing dominance of hospitals meant that work and skills undertaken in community settings were poorly seen. In order to provide quality care, collaboration, between agencies and professionals who work in them, is essential (Berendsen et al. 2009). The use of shared assessment and shared notes is also mooted in the findings, but to date previous innovations such as the single assessment process have had some success, but not delivering the whole systems agenda as hoped (Wilson et al. 2007). Even where it was embraced professionals maintained their own notes as well thereby creating more work than previously, because there were tensions along professional boundaries and around person centred values (Miller and Cameron 2009). Again, the analogy of a 'jigsaw of care' (section 6.52) is pertinent to the idea of a whole systems approach. Additional discussion of this point with my Master's students developed the idea further. They considered that service and role re-design could be seen as altering the shape and size of the jigsaw pieces thereby increasing complexity of a 'good fit' and hence the ability to effectively coordinate care, to build integration and to sustain a whole service approach to care when community matrons are only one piece of the whole.

7.423 Self-management and independence

In the discussion I will now explore self-management and independence which forms a part of the patient journey. In their interviews, former commissioners talked about dependence which grew up around the community matron / patient relationship. This was a factor that they also linked to caseloads becoming full. Some matrons did also note dependence as a factor early on after the role was instigated. It became clear to these matrons that changes were needed and findings show the lengths and strategies employed to change the relationship and make it more about partnership. When interviewing patients and family carers I was struck by the way they got on with life. Although they used very obvious strategies for managing themselves in relation to their health, they did not appear to think them out of the ordinary, arguably showing adaptation, if not adjustment to their altered health status (Thompson 2011). As Taylor and Aspinall (1996) note, most people do adapt to living with a LTC.

There is recognition by community matrons that for many of their older patients the partnership approach to health is quite new. It takes time to adapt from 'doctor knows best' to what Boddenheimer et al. (2002) describe as a new paradigm, that of partnership. It probably goes without saying that even when paternalism was the order of the day, individuals may have chosen to ignore instructions given to them. As Glasgow and Anderson (1999) describe, when patients leave an appointment they can and do veto suggestions from HCPs. There has to be some mediation on how a regime will fit with an individual's life and how much sacrifice that entails. One participant in the study (Rory), who was a very knowledgeable man in relation to his co-morbidities and his medication, chose to omit his lunchtime dose of insulin if he knew it would affect something else he wished to do.

Building self-efficacy (Bandura 1977) to enable patients to have the confidence to self-manage can be time consuming and difficult to document thus leaving the work of community matron's invisible. As Roy (2000) states, it is important that trends in nursing are publicised to ensure visibility. Working with patients to achieve self-management is arguably one such trend.

7.424 Discharge

A desire to manage and be independent was seen as part of a desire to avoid hospitalisation at all costs according to community matron, Liz (section 6.57). Indeed, a study which explored hospitalisation for an acute episode found that patients with co-morbidities expected problems to develop in hospital which made them apprehensive about admission and left them resigned to managing additional problems after discharge (Williams 2004). Ray commented on a hospital acquired infection which kept him as an inpatient for 31 days and significantly weakened as a result.

Findings in this study note positive and negative examples of hospital discharge and Williams (2004) describes little acknowledgement of the underlying co-morbidities when patients are discharged from hospital. Discharge from hospital is a well-documented theme in nursing literature yet despite an evidence base, difficult situations continue to arise. In their findings, Bauer et al. (2009) state that there is a direct correlation between poor quality of discharge and readmission to hospital. Community matrons, particularly in area 1, but also to some extent in other areas, go to lengths to continue case management, albeit at arm's length when patients are hospitalised for the very reason of being available to coordinate a smooth discharge. As discussed previously, (Kelleher 2003), the poor understanding between acute and community and the roles of individuals within each subsystem persists.

Discharge from community matron caseload is a relatively new concept and as described through participant comments shows that some matrons who have been in post since the beginning have found it quite difficult to reconcile such changes. For some matrons, the service which was set up to be proactive and to prevent crisis has become the opposite. Arguably, if patients have become effective self-managers this should not present such a problem, but success and prevention of admission to hospital is reliant on patients activating an early warning system and calling the virtual ward for help in a timely manner. For some matrons, the inability of being able to provide care around quality of life issues in a holistic way rather than just treating exacerbations loses some elements of care. Arguably, allowing patients to be discharged and re-admitted to the virtual ward for 12 weeks (except in certain circumstances such as end of life) could mean that patients are not case managed at all with limited attention given to domains

other than those in domain A of advanced clinical practice utilising health assessment and non-medical prescribing. That use of a virtual ward emphasises a medical model rather than a bio psychosocial model and a nursing model may fundamentally affect the embedding of the community matron role. The aspects of care which are valued are the technical skills which obviously keep patients at home, such as diagnosis of a chest infection rather than the need to organise respite care so that the carer can receive a break. That, through skill mix, some staff lack experience with technical skills was also presented in the findings.

Aspects of the findings presented and discussed under this theme have in part met the study objectives. Operationalising case management is considered in relation to care coordination and self-management. Objective 2, how the role and service design has been embedded in light of policy initiatives and emphasis on reduction of hospital admissions is considered in light of both qualitative and quantitative data on hospital admissions. Finally this theme has also explored aspects of care which are valued, notably in sub sections on care coordination and self-management and independence.

7.42 *'I can't walk away': the invisible role of the community matron*

In this chapter, I now present a discussion centred on invisibility of aspects of work undertaken by community matrons. Sub-sections include: value of the services to patients and family carers, emotional impact on the community matrons of the role and time taken to achieve successful outcomes.

7.421 Value of community matron work as seen by patients and carers

This theme has been framed in relation to the community matron role and how it is valued by patients and family carers, the emotional impact on community matrons and the time it takes for them to do their work. Value is particularly considered in terms of boundary work, so work which may not be nursing. Fetching medication and working outside of planned hours are two examples. Neither aspect is strictly part of the role, but not undertaking these aspects could result in a bigger problem and even hospitalisation. It could be seen as creating reliance rather than independence, but in the case of medications, these were emergency situations and in the case of the 'off duty' issue the matron is clear with Harry that his behaviour was not acceptable (section 6.61). These aspects of care are not likely to be seen or recorded, because they may be considered as

‘bending the rules’ (Smith and Sutton 1995). Such work may depend on personal qualities of the individual community matron as it does not form a formal part of the role. As Goodman (2001) explains, nurses often exhibit skills which accommodate conflicting demands so that good care is provided to patients. However, it could be argued that such examples which focus wholly on the patient prevent community matrons from engaging with wider issues which may make them more visible in the policy landscape (Maslin-Prothero and Masterson 2008).

7.422 Emotional impact on community matrons

Findings show an emotional impact on community matrons as a result of the work they undertake. A lot of the issues portrayed are affected by poor communication across professional boundaries. This highlights the fragmentation of care which Liaschenko (1997) notes prevents the smooth journey of the patient. Nurses, according to Liaschenko (1997), frequently cross the gaps to fill the spaces. Findings in this study show how community matrons often fill the gap where other agencies have not responded in a timely manner or have not accepted a referral. As this theme title notes: *‘I can’t walk away’*, which illustrates the community matron’s dilemma. Since the division of health and social services in 1971, there has been a tension between the two services (Wilson 2007). Examples presented such as Sally working with a client to sort out pension issues is arguably not nursing, albeit remains true to patient need and is problem solving but may be closer to social care. Is it nursing as a discipline which is different in filling these gaps or is it the individual personality of the post holder who takes on these additional and unseen aspects of work? Either way, this is not nursing in a biomedical context, but rather a holistic interpretation which values that maintaining health is more than physical well-being alone and that social factors impact the physical and mental well-being. Without her pension, the lady in question cannot buy food, pay for heating and in borrowing from a friend risks loss of their social contact if this is perceived to be a problem by the friend. This is more than an inter-personal bond, and rather an example of what Liaschenko (1997) calls a structural relationship where other agencies do not work in a timely manner to be useful so the nurse fills the gap because of shared connection and circumstances. This could be an example of community matrons lacking power (as noted for other nurses by Liaschenko 1995). Although

community matrons are autonomous, this may be an example of other agencies not recognising their legitimacy, which could be as a result of the community matron not being visible to other agencies. In speaking and acting for patients, community matrons show what Liaschenko (1995) describes as 'artificial personhood'. This has the potential to create moral distress because the community matrons see problems, try to fix them because they cannot always get the support they require. Arguably this could be harmful to patients because in working outside their remit community matrons may not have all the facts or skills needed to advise appropriately and as such are caught in between competing values and interests (Varcoe et al. 2004). However, in noting throughout this work, that the role is poorly defined there may be latitude which allows such boundary work to be part of the remit. In which case, education which allows the community matron to be better skilled in such areas could be a solution. As Graham (2010) contends, this would require vision and leadership from nurse managers. It has been demonstrated by participants in my study, that community matrons have a great capacity to meet the expectations of other HCPs, yet this can lead to harm for them as individuals and the profession, as much of the work is not seen (Goodman 2001).

7.423 Time: in relation to documentation and care coordination

Reports from community matrons showed their anxiety that they could not account for the time it took for them to undertake their work (section 6.63). Many of the findings present examples of work which may only be documented by a sentence or two, such as continuing care documentation completed. Such a document is large (48 pages) and requires considerable time and effort. Other factors of work are similarly hard to quantify and matrons report being questioned about quantity over quality. Rodney and Varcoe (2001) note that rationing often comes from a poor understanding of what nursing comprises. It is often the relational work which is hard to record and yet relational work connects patients to the whole process and as such a more effective healthcare journey (De Frino 2009). Sherwood and Horton-Deutsch (2012) describe nursing as a value based profession associated with emotional labour which can take its toll on nurses. They argue that when work is counter to values, as described in my study, nurses can become disengaged and cynical, ultimately affecting the quality of care provided to patients. Although I do not consider that my study shows quality of care to

patients is affected, I consider this is because community matrons often go beyond their prescribed role in order to protect the patients in their care, often at personal cost, as described by Huynh et al. (2008). This personal cost may be undertaking paperwork in their own time which should have been done at work, had the work time not been taken up on boundary work.

Overall, community matron work is visible to those working closely with CMs. As Liaschenko (1997) notes, those who are in the landscape. However, that the CM role has undergone so many changes which have affected embedding of the role is arguably a flaw in the overall healthcare system which continues to value an acute hospital healthcare system and metrics which are easily measurable. As autonomous practitioners, it could be considered easier to exert their role and for that role to be seen overtly. This is not the case.

The sub section on value of community matron work explores aspects which are important to participants in line with the objective. Sections on emotional impact and time, in part meet the objective of factors which affect embedding. The whole theme can be considered in light of the objective of using Liaschenko's lens, exploring invisibility and embedding.

I have presented a discussion in relation to the findings in my doctoral study. Where these findings link to existing literature links have been made. At other times I offer my own interpretation. As an overview there are many synergies associated with invisible work and boundary work but also the 'landscape' in which community matrons' work. Although Liaschenko's work (1995, 1997) explored concepts in American nursing, I consider that this work translates to a UK context. Beyond this, the work of Graham (2010) also offers valuable insight into the dilemma of 21st century nursing. Findings in this study could also strengthen Graham's assertions. Community matrons are largely focussed on the person and micro aspects of care from a holistic viewpoint. Watson (1999) states that 'being' which is more than the physical but encompasses an individual's job, relationships and life choices need to be valued in nursing to make the nursing care offered to patients complete. That quality of life is an important part of what community matrons strive to do even when death is likely shows an appreciation

of 'being'. Graham (2010) concludes that nursing experiences which come through person to person contact positions nursing as: '*the science of knowing people and their needs.*' (Graham 2010: 358). Community matrons offer valuable insight into their daily work which does just this and in addition seeks to meet patient and person needs by dealing with boundary issues in healthcare and sometimes outside.

7.424 Summary: person, visibility and embedding

Again, in this section I have discussed factors which can be seen to have an influence on the visibility of the role if community matron. In summary, these comprise:

- Patients and carers continue to voice their approval of this role. It is clearly visible to them.
- Acting as patient advocate can raise visibility of community matron role but in a way that may antagonise other HCPs.
- The ability to gain acknowledgement that time spent talking to patients is a means of therapeutic intervention which builds rapport and may lead to health transitions.
- Means of portraying the time taken to coordinate care which is often not seen.
- Emotional impact on community matrons of undertaking a complex job which is frequently underestimated because many aspects have limited visibility to other HCPs.

The factors summarised in 7.219, 7.318 and 7.424 are all contributory to ineffective embedding of the community matron role. How generalisable the findings are is debatable. This was discussed in section 5.92. New roles are often introduced in nursing. Although my thesis has looked specifically at the role of community matrons and issues surrounding embedding, there are some transferrable factors which would impact on any role. A clear vision and objectives which align with other services in the NHS would be a valuable start. That the community matron role vision was for a service which operated 9am-5pm, Monday –Friday, was one factor which made embedding difficult and led to numerous service delivery changes. Future innovations could learn much from past issues, such as those portrayed here.

7.5 Chapter Summary

This chapter has discussed and offered an interpretation of the findings from the QUAL and quan aspects of my study. The themes have been considered in relation to policy which I chose to replace case and patient and person as highlighted by Liaschenko and Fisher and re-examined in light of my own data.

Chapter 8: Summary and Conclusions

8.1 Thesis overview

When I started work on the parent project in 2008, I was excited and optimistic about examining the effectiveness of a community matron service. Naively, I did not expect to encounter the difficulties which arose in showing what community matrons do and how this had an effect on patients, family carers and other services. The narrow metric of preventing hospital admission was held above all others as being important by the funders of the parent project, albeit that they felt that metric would be most likely to hold 'sway' with commissioners. Additional seeds were sown in my mind around how nursing roles embed and how nursing is seen. The work of Joan Liaschenko (1995, 1997) and later Liaschenko and Fisher (1999) led me to consider invisibility in nursing. An additional review of invisibility literature showed that there is a gap in relation to autonomous roles, such as community matron, in a community setting. Constant changes to the role of community matron mean that the work of community matrons needs to be overtly visible if the role is to grow, embed and ultimately survive.

Globally, the world is ageing and with ageing (although not exclusively) comes an increase in people developing long-term conditions. A desire to find ways of effectively managing individuals with LTCs appears throughout policy. One possible solution was the introduction of the community matron role to act as case manager and coordinator. The aim of the new role was to pull together fragmented services for patients and offer advanced nursing skills in patients' own homes. This was examined in chapter 1.

In seeking to answer my research question: **What factors affect the embedding of the nursing role of community matron?** in chapter 1, I have offered a context for the question. Background topics around long-term conditions, advancing practice and new roles have been explored.

Chapter 2 explored literature on case management and secondly on invisibility in nursing offering a historical and contemporary view on both areas.

Difficulties associated with understanding nurses' work, some of which is at the margins of nursing and often deemed invisible led me to the work of Liashenko and others. This was presented in chapter 3, offering a theoretical perspective for my study. My work has examined how Liaschenko and Fisher's (1999) theorisation may work in an English context through the community matron role. I also consider that the work of Liaschenko and Fisher (1999) offers opportunities to explain nursing which occurs across what they term case, patient and person. Arguably, though using the work of Liaschenko and Fisher as a theoretical base has been contested because my own work did not provide an exact match to case, patient, person and as such I chose to replace case with policy in my own work.

Chapter 4 allowed me to explore methodological theories and to provide a rationale for my choice of a mixed method study (QUAL quan). This enabled me in part to explore the effectiveness of community matrons in relation to hospital admissions (quan) and the wider aspects of the role which are less easy to explain and see by others not undertaking the role. In choosing this design in my study, it has honed my research skills as part of a learning process. I know that what I have learned through this experience will be useful in future research.

In chapter 5, I provided insight into decisions made relating to methods and set out how the methods were operationalised in order to gather pertinent data.

The findings from QUAL and quan are amalgamated and were presented in chapter 6. Findings from the examination of patient journeys revealed an impact on hospital bed days as a consequence of having a community matron. Such findings were not replicated in the larger data set explored, which were examined using SPSS 20. As qualitative data from the parent project gave many examples of proactive practice which was considered to have an impact on hospital admissions as well as offering many other examples of work undertaken, this data was re-examined. Qualitative data was collected in a further two areas. The qualitative findings were analysed through a framework and are presented thematically. The themes are: *'agreeing ways of working without understanding'*: implementation of community matron roles and effects implementation of the role and effects, *'a little bit of extra effort'*: delivery of health care by community

matrons, *'climbing Mount Everest'*: psychosocial aspects of living with an LTC, *'a jigsaw of care'*: patient journey and *'I can't walk away'*: the invisible role of the community matron.

An interpretation and discussion of my findings (QUAL quan) is offered in chapter 7. The themes have been considered in relation to policy, patient and person as highlighted by Liaschenko and Fisher and re-examined in light of own data.

8.2 Chapter Introduction

I now present concluding comments in relation to the findings. My focus in making these comments is to provide 'take home' comments for nursing, particularly as they pertain to how nursing is seen (or not: visibility versus invisibility) and how visibility and other factors affects the ability of a new role to embed. As my doctoral study concentrated on the role of community matron, I add a caveat about how far my findings in relation to the community matron role can be transferred across nursing as a whole.

8.3 Concluding comments

Some of the findings from my doctoral study are in line with other writers conclusions in relation to the community matron role, as noted in chapter 7. Briefly these comprise the popularity of the role (generally speaking) as noted by patients and carers, community matrons, and GPs. My study also shows positive regard for aspects of the role from former commissioners.

Exploring the patient journey of area 1 patients who had been interviewed showed that 83% had reduced hospital admission since being on the caseload of a community matron. However, the exploration of this in relation to the larger dataset, comparing patients who had a community matron and those who did not, found that there was largely no statistically significant difference between the intervention group (community matrons) and the comparison group (no community matrons). Qualitatively, patients and family carers generally reported less hospitalisation. The community matron participants also gave numerous examples of saved admissions (section 6.53). The latter are difficult to record showing how work that is valuable to patients and carers and also has an impact on hospital admissions is hard to record and make visible. In turn, the

relative invisibility makes the work of community matron more at risk of repeated change which fails to allow embedding of the role. That CMs are considered autonomous practitioners and yet cannot get their work universally recognised outside of close working partnerships with patients, GPs and former commissioners, as detailed in my work, is a new dimension to the invisibility of nursing debate. In 1999, the Audit Commission noted that the work of DNs was invisible. Although, the level of autonomy is different between DNs and CMs, it has lead me to consider that the issue of invisibility may be about a poor understanding of the work undertaken in the community setting, rather than autonomy of the role. When considered in light of Lupari's work (2011) which found case management to be both effective and cost effective, this has not made the community matron services in my study, who are undertaking case management any more visible. This would bear further investigation.

Obtaining data from three separate geographical locations has highlighted some differences. In concluding, the embedding of the community matron role in area 1 was impeded by a limited strategy to ensure new community matrons had appropriate access to education aligned to their new role. In these I include skills around health assessment, non-medical prescribing, long-term conditions and leadership. Additionally, the breadth of the role undertaken was difficult to record and therefore less visible to other HCPs. As this data was collected in 2010, it does not encompass service re-design which followed and is known anecdotally to me. The parent project evaluation which sought to explain the work of community matrons in area 1 did not protect the service from change.

Qualitative data collected in area 2 and 3 was collected in 2012 and highlighted service changes in these areas. Findings of this study show how constant change to service delivery models has impacted on the role of community matron and on the individuals holding those posts. As a consequence of increasing capacity through service re-design and introduction of teams, community matrons have found themselves providing less direct patient care. Reduction in direct contact with patients is particularly noted in area 3. This is a trade off, and contradicts the introduction of senior clinical roles which aimed to keep highly skilled nurses in practice and with close patient contact rather than them

moving to management or education. Both management and education impact patient care, but indirectly. Findings in area 3 also highlight the complexity of working with a 'double system'. In area 3 some matrons lead a virtual ward, whilst others work as autonomous practitioners. Some community matrons have reduced patient contact, but increased capacity to provide a service to individuals with long-term conditions via a skill mixed team. Autonomous community matrons maintain high levels of patient contact but are hindered by caseloads at capacity. These changes impact on the ability of other health professionals to keep abreast of changes, as noted by GPs interviewed. This is of particular concern because the GPs interviewed were purposively sampled and had a direct interest in LTCs and still struggled to grasp changes in service delivery by community matrons in area 3. (Of note, recently [Dec 4th 2012] area 3 decided to re-name virtual wards as long-term condition teams and include district nursing and intermediate care under the term. This is another change which my study mentions to show currency but cannot explore. This information was imparted at a meeting I attended. How autonomous community matrons fit into this 'new' design is not clear to those working in that autonomous capacity).

Area 2 findings from community matrons, managers and former commissioners also reports a number of changes in service design affecting community matrons. My conclusion surrounding embedding in area 2 is that the community matron role has been limited by poor integration with the DN service. As a result the ability to step up and step down patients in response to clinical need and therefore offering increased capacity to manage greater numbers of patients with LTCs has not been achieved. The need for effective integration arguably requires a national re-design and alignment of district nursing for the 21st century, as has been undertaken for health visiting. This is beyond the scope of my thesis, but I note this may be imminent following the release of a vision and model for district nursing (DH 2013).

Findings from all 3 areas point to a complex system of healthcare of which community matrons form a small part. Constantly re-designing their role without considering a wider perspective affects embedding of the role. In particular, how a new role such as that of community matron can fit with existing services such as district nursing has been

poorly considered and executed. In turn this constant change (albeit small changes) can demoralise those in the role and affect the understanding of referral processes and work undertaken. Generally, I conclude that patients are protected from the changes as much as possible by community matrons, arguably at some cost to the matrons themselves.

In summarising, these issues may be seen as a 'catch 22'. The constant changes to the community matron service may be a symptom of the community matron role not being visible. However, the constant changes also make it difficult for the community matron role to be visible. Other HCPs who look for the community matron no longer know what to expect from the service.

Largely, I consider that my work has met the study objectives. It has examined how the role of community matron is operationalised through case management and in light of findings, discussed how this has weakened over time. It has considered how the role and service design has been embedded in relation to policy initiatives and the emphasis on reduction in admissions to hospital, concluding that embedding has been difficult. This is not least because the original vision of the community matron service was flawed in service design, most notably working hours and issues of capacity. My study has shown how these factors have been addressed through numerous service redesigns leaving fellow health care professionals confused. The study explored aspects of the role and provision of care which are valued by community matrons, patients and family carers, managers, GPs and former commissioners. All groups saw value in the role. However, as discussed, this must be considered against the use of purposeful sampling and where participants sit in 'the landscape' as Liaschenko notes. Factors which have impacted on embedding of the community matron role have been examined in light of data provided by community matrons. The numerous aspects of their role which are hard to articulate and document have been presented and link with the reduced visibility of the role. The theme titles: *'a little bit of extra effort'* and *'I can't walk away'* sum this up.

Finally, I considered whether using the lens of Liaschenko and her reports of nursing work being invisible help to explore embedding of the current role of community matron. Again, in part, I believe that examination of invisibility and also of boundary work is important and both aspects have had some effect on the limited embedding of

the community matron role. Further examination of a language which explains nursing may help future roles embed more successfully on a local and national level and make the invisible visible.

The qualitative aspect of the study provided 5 themes (chapter 5 and appendix 14).

These were:

- *'Agreeing ways of working without understanding'* : implementation of the role of community matron and effects
- *'A little bit of extra effort'*: the delivery of health care by community matrons
- *'Climbing Mount Everest'* : psychosocial aspects of living with a long-term condition
- *'A jigsaw of care'* : the patient's journey
- *'I can't walk away'* : the invisible role of the community matron

As part of interpretation and discussion I aligned the 5 themes into an adapted version of Liashenko and Fisher's (1999) work (chapter 8 and appendix15):

- Policy (macro)
 - *'Agreeing ways of working without understanding'* : implementation of the role of community matron and effects
- Patient (meso)
 - *'A little bit of extra effort'*: the delivery of health care by community matrons
- Person (micro)
 - *'Climbing Mount Everest'* : psychosocial aspects of living with a long-term condition
 - *'A jigsaw of care'* : the patient's journey
 - *'I can't walk away'* : the invisible role of the community matron

I consider that this offers a framework by which the work of community matrons can be articulated which might be a useful tool for clinical commissioning groups.

In particular, I consider the following areas offer new insights, as a result of my work, and are factors which my research have shown to affect the process of embedding the role of community matron (the use of numbers is not intended to rank ideas in relation to importance, but rather to offer a means of signposting):

1. A move away from the domains of case management (table 1) as a formalising structure for the work of community matrons.
2. Some service delivery changes (fast response, introduction of VWs) in relation to the role of community matron have impacted on direct patient contact time.
3. A dichotomy is apparent on what constitutes clinical leadership and how this differs from managing a service. Again the impact is a reduction in direct patient contact.
4. Some reported changes in service delivery model (particularly VW) for community matrons appear to be in line with the medical model rather than a biopsychosocial model.
5. Elements of success are noted as a result of service model change such as increased working hours by community matrons, and reducing barriers, promoting integration and effective discharge from secondary care.
6. Discharge of patients from community matron caseloads can be problematic.
7. There is a hidden population of individuals with LTCs who could benefit from case management by community matrons.
8. The idea of a 'jigsaw of care' being required to make a whole systems approach, of which community matrons form one piece.
9. That autonomy in the role might lead to improved visibility is not apparent. The critical factor may be that community nursing in general remains poorly understood, seen and articulated.

Consideration is given to how these factors have impacted on embedding of the community matron role. Some changes appear to result from the work of community matrons being less visible. All nine areas are considered in light of the research question and objectives.

1. A move away from the domains of case management (table 1) as a formalising structure for the work of community matrons.

Shortly after inception of the community matron role, competences were devised around case management, offering a structure around which the role could build. This is in line with the objective which sought to examine how the role was operationalised. Discussion around the framework being less well used can be found in section 7.21. It could be argued that reduced emphasis of the domains of case management dilutes the ability of community matrons to explain what their work comprises and as such, goes some way to shedding light on a factor which affects embedding. I would suggest making use of the framework on domains to promote their work. If not utilising this framework, then creating a new framework which can be used to show the complex work undertaken may be required. Any model should encapsulate the role in light of macro and meso facets of healthcare and not the micro patient facing work alone thereby making the role more visible to CCGs (chapter 7 and appendix 15).

2. Some service delivery changes (fast response, introduction of VWs) in relation to the role of community matron have impacted on direct patient contact time.

As a result of service delivery change community matrons report spending less time with patients utilising the high level of clinical skill they have built up. This finding is polarised from the idea that the role of community matron would offer a means of keeping highly skilled nurses with patients rather than them moving to management or education in order to gain promotion. This partly offers an answer to the objective of how role and service redesign has been embedded in light of policy initiatives. This directly links and is expanded in point 3.

3. A dichotomy is apparent on what constitutes clinical leadership and how this differs from managing a service. Again the impact is a reduction in direct patient contact.

Although the domains of case management stated that professional practice and leadership was an aspect of case management, community matrons in area 1 largely struggled to interpret their operationalisation of this domain. In areas 2 and 3, community matrons were expected to enact clinical leadership in their role, particularly in relation to district nursing colleagues and the skill-mix staff on the virtual ward. This led to tensions particularly with district nurses. Managers of the service saw clinical leadership as involving aspects which directly affected patient care. In this the managers included ensuring correct skill mix available, dealing with patient complaints and day to day running. Community matron participants saw these aspects as management akin to the role of ward manager in secondary care. Although acting as clinical resource for other team members, the result was a reduction in day to day patient care and a perceived loss of high level clinical skills (perceived because I have not directly investigated this; it comes from self report) which had been gained over many years and included the cost of education and mentorship time. Many matrons who took the role for the very reason that they wished to remain clinical and patient facing had the perception that this ideal had been eroded and led to acute distress in some.

4. Some reported changes in service delivery model (particularly VW) for community matrons appear to be in line with the medical model rather than a biopsychosocial model.

Many service model changes were in answer to capacity issues and community matron caseloads becoming full. These changes affect embedding. Utilising skill mix via a VW model offered greater capacity. The extension of hours in areas 2 and 3 was noted as advantageous because it allowed acutely ill individuals to be monitored by a community matron thus preventing some emergency admissions to secondary care. However, the virtual ward model could be seen as an extension of secondary care and thus akin to the medical model. Discharging individuals from the virtual ward has the potential to create a reactive service driven by crisis and exacerbation. For patients who exhibit effective self-management skills this may be avoided, but findings note the time and effort required to establish such skills. Ability to embed

them in 12 weeks may be questionable. Patients and carers alike note the value of community matrons providing a safety net even if they do not visit regularly. In dealing with exacerbations only, utilising a biopsychosocial model or even a nursing model may be lost next to the need to manage an acute episode. Much of the work undertaken by community matrons has not been seen or understood by former commissioners and to some degree, their managers, hence a move back to the medical model which can be seen as a driving force in secondary care. This has some synergies with Liaschenko's work that nursing is invisible and links to that objective.

5. Elements of success are noted as a result of service model change such as increased working hours by community matrons, and reducing barriers, promoting integration and effective discharge from secondary care.

The success of increased working hours is apparent. Changes in service delivery models, particularly in area 3 where Transforming Community Services led to amalgamation of community and acute has reduced barriers, led to increased integration and improved flow in discharge from secondary care to community. However difficulties persist because skill mix teams do not have the same level of skill as the community matron. GPs report this as problematic at times. Again the role does not embed, rather changes and skills and holistic understanding of how patients' lives affect their health is lost in the desire to speed up processes.

6. Discharge of patients from community matron caseloads can be problematic.

Although mentioned in relation to the VW, discharge from community matron caseloads can be problematic. Attempts in area 2 to step down patients to district nurses during times of stability and the expectation that patients will be referred back to community matrons on exacerbation highlights a more complex problem for nursing. It may be considered that district nursing has been underfunded and left adrift in relation to changing healthcare needs, expected to pick up work which other services will not and therefore not in a position to work in an integrated way to support the community matron role in effectively managing the growing population of individuals with long-term conditions. Sub sections of nursing (and wider health

and social care) fail to unite with common vision. Teaching self-management skills in hospital in relation to patient independence rather than an assumption that a community nurse is required could lead to opportunity for change. As reported in this study, poor understanding of the role of community matron, the work undertaken and goals of care mean much care is unseen. It is unseen by fellow nurses as well as other HCPs although not the former commissioners and GPs interviewed in this study as noted in study limitations (section 5.8). This directly impacts how the role can embed when constant change is implemented.

7. There is a hidden population of individuals with LTCs who could benefit from case management by community matrons.

Investigating PARR data in area 1 and the ease with which it was possible to create a comparison group matched to the intervention group of individuals' case managed by a community matron shows that there may be considerable unmet need. Although a small sample, it was not difficult to find 106 patients to match, all of whom exhibited similar characteristics which should allow them a community matron. This offers one explanation for the amount of change which the community matron service has undergone and directly links to the research question. In order to embrace constant change, support mechanisms need to be in place which offers strong leadership to individuals in 'new' roles to ensure continuing effectiveness and not demoralisation and poor understanding. The limited availability of a successful case finding tool inhibits the ability to find hidden populations and hinders the visibility and embedding of new nursing roles such as that of community matron.

8. The idea of a 'jigsaw of care' being required to make a whole systems approach, of which community matrons form one piece.

Ideas which can be visualised can be powerful. In some senses this term, suggested by Olivia, encapsulates how services within health, social care and the third sector need to work together to optimise care for individuals who live with long-term conditions, especially those whose health is most fragile. The analogy of the jigsaw links to Liaschenko's analogy (1997) of tectonic plates which continually move leaving patients at risk of falling through the cracks and of nurses battling to fill the

gaps. In using both analogies, the work of community matrons is at risk of not being visible and that failure to embed can make the role more vulnerable to being a 'poor fit' with other health and social care services.

9. That autonomy in the role might lead to improved visibility is not apparent.

The critical factor may be that community nursing in general remains poorly understood, seen and articulated.

There is limited consideration within the invisibility literature of autonomous roles and community settings. My initial thoughts were that being autonomous practitioners should allow CMs to be more visible and be able to promote their role thus allowing the role to embed. However, constant changes in service design have impeded visibility even for those who work closely with CMs. GPs in my study note confusion at constant change. It has led me to question whether the real invisible factor is work in the community rather than autonomy.

Overall, community matrons, as autonomous practitioners appear to be no more successful at making their work visible than other nurses discussed in the literature on invisibility in nursing. The findings of this study, and recommendations that I have made could help to address the question in the title of my thesis: making the invisible visible?, as they give pointers for service commissioners, managers and community matrons themselves to help to make the work of community matrons more visible.

Original and significant contribution to the literature

As far as I am aware, this study is the first to take a mixed method approach to the nursing management of long term conditions in community settings. Previously there has been an assumption that having a community matron assigned to case manage patients with long term conditions would result in fewer days spent in hospital, and the prevention of hospital episodes. This study showed in the larger data set that this claim cannot be substantiated. However, I consider that the advantage of a mixed methods approach is to provide a more balanced view of community matron's work, enabling a more complete assessment of the impact of service innovations, and that the advantage is twofold. Firstly, not to leave the consumer of this research with the message that

providing community matrons is a waste of resources. Rather, secondly, to balance the view of community matron's work by adding the qualitative views in which the value of their work in community nursing is held in high regard by a number of the stakeholders (patients, their carers, former commissioners and GPs). This view emerges plainly, notwithstanding the study's use of purposive sampling. The benefit of a mixed methods approach is then to allow us to explore the process of case management in community settings, not just the outcomes, not just how people feel about the service but to evaluate the process, and crucially to see previously hidden factors which disrupt the embedding of community matron services. A strength of this study is that it was conducted across three separate geographical areas each with its own cultural and contextual history in embedding community matron services. Thus, this is the first study to use a mixed methodology to examine the process of embedding case management in different areas, and different service context.

The thesis has built on the work of a number of authors who have examined invisibility in nursing. Where it is unique is in considering these factors in community settings and in the work nurses do across the boundaries of the community setting and the hospital setting. While other studies have focused on outcome measures such as cost effectiveness (Lupari' 2011) and reduction in hospitalisation, this is the first study to apply the lens of invisibility in nursing to the work of community matrons. As has been discussed in my thesis, previous attempts to demonstrate the value of community matrons role have not prevented numerous service redesigns, often enacted without consultation with community matrons as senior community nurses.

The lens of invisibility may help nurses, not just community nurses, to be aware of the social and political dimensions of their work. As suggested here for the first time, adapting Liaschenko and Fisher's case, patient person to policy, patient and person may allow nurses to connect health policy and service designs to the needs of people to whom they deliver nursing. By considering how to make their work more visible to those with power to design, fund and evaluate services, nurses may be able to prevent services being evaluated using narrow outcome measures (which they are unlikely to be able to use to demonstrate the value of their work). Instead they would make the value

patients, their carers and GPs see in their work visible. Applying the sort of mixed method approach used in my thesis may well allow community nurses (and other nurses) to show the process of case management for people with long term conditions, accounting for and balancing a broad range of factors. These factors would include evaluating how to recruit and retain experienced nurses to spend time interacting with people with long term conditions, and how to avoid role confusion which directs nurses away from patient contact and in to leadership, research or educational roles.

As such, my thesis adds a new perspective to a historical nursing argument of invisibility, as well as further highlighting that an autonomous role is no more successful at embedding.

8.4 Recommendations

8.41 Policy

Policy is formed at many levels impacting on service delivery. Broad ideas emanate from the Department of Health, which then need to be operationalised at local level. Within my thesis, there is evidence that this operationalisation of the role of community matron has been difficult, lacked vision and resulted in multiple service re-designs (section 6.2). Where policy is directed at the creation of new roles, consideration is required in relation to strategies which look further than implementation alone to sustainability and embedding. Using the Liaschenko and Fisher adapted model (section 8.44) may offer a means of ensuring the vision associated with a new role is maintained in practice. The use of policy to drive the design and implementation may allow the work of community matrons to be more visible to CCGs and other HCPs.

8.42 Practice

In establishing policies (usually at organisational level) which consider longer term aspects of new roles, certain factors noted in the literature and in empirical findings suggest areas which are neglected. These include *ad hoc* set up, lack of consensus around remit and lack of support of roles following implementation. The technical skills of advanced health assessment and non-medical prescribing require mentorship. In areas 1 and 3 mentorship was unstructured and therefore problematic. Area 2 had a

strategy for managing mentorship early on after role inception. This is an area which practice must address if roles are to be effectively embedded and post holders fit for purpose. This requires practice to invest in a robust policy which provides effective mentorship. In so doing, community matrons will be in a stronger position to have some aspects of their role (advanced health assessment and non-medical prescribing) seen more clearly. In addition, how district nursing works needs investigating to support individuals with LTCs. A directive from national policy level (DH 2013) may assist in a redesign benefiting both community matrons and DNs ensuring a national consistency in approach and a better understanding of the work which goes on within a community setting. Finding effective process or outcome measures which show the value of work undertaken by community matrons (and other nurses) is required to inform commissioning groups.

8.43 Education

Links between practice and education need to be strong in order to provide a framework which meets practice requirements in relation to new roles. Acknowledgement of different needs between training and education need to be understood. In the role of community matron, an educational framework was not always strong. As is often the case, those individuals who came into post early were effectively up-skilled, but subsequently up-skilling did not remain as high on the agenda. This arguably weakens the role if community matrons are seen to lack important skills to undertake the role. In turn, if community matrons are considered unfit for purpose, this is likely to affect embedding.

By further adapting Liaschenko and Fisher's (1999) model, a framework for nurse education in general is suggested. In adding policy to the original framework of case, patient, person, much of what nursing endeavours to be is included and may be a useful tool to portray 21st century nursing. In addition, macro, meso and micro is included on a continuum (figure 21) to impress that 21st century nurses require knowledge and skills which are broader than patient facing alone:

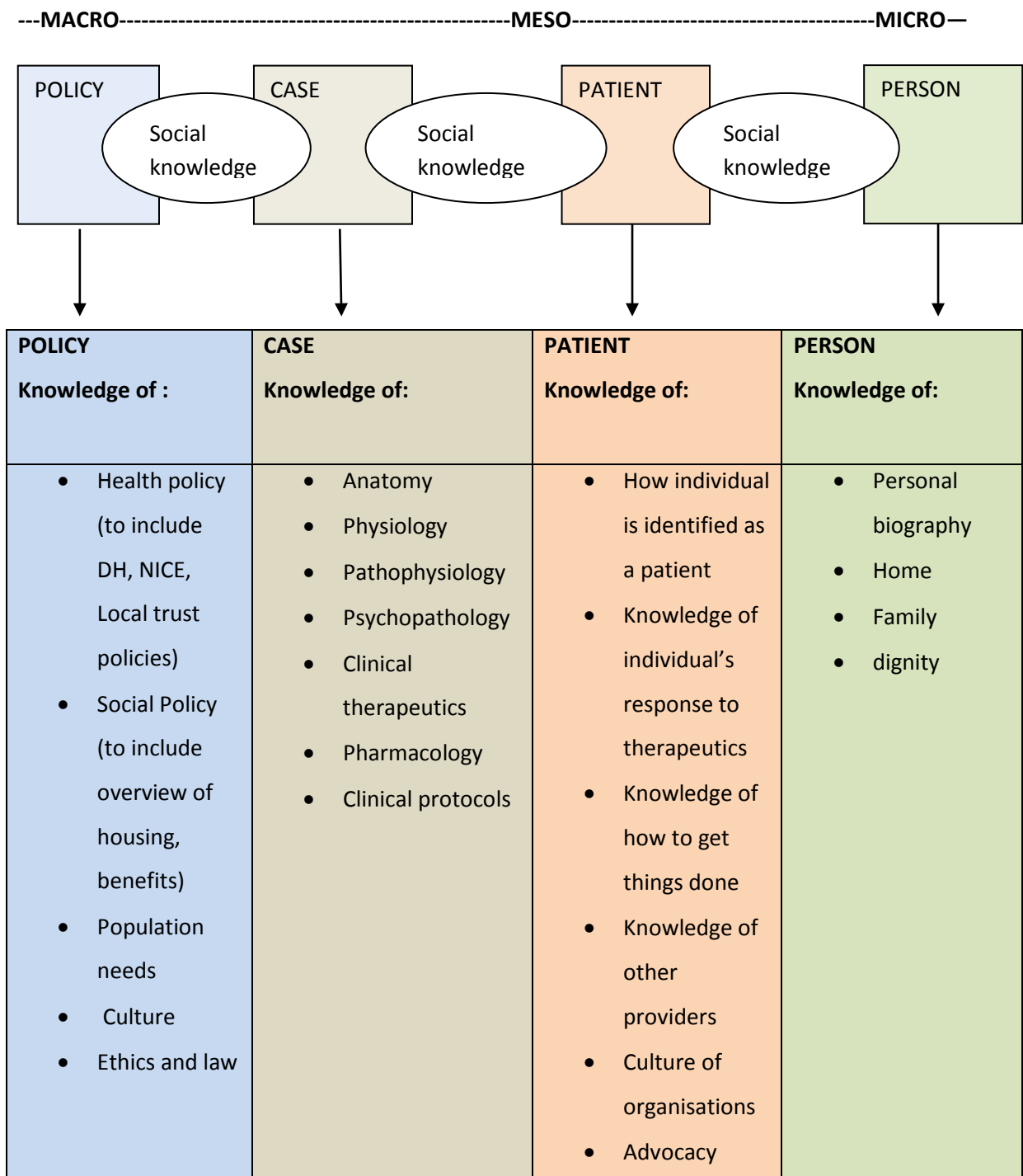


Figure 21: Adapted knowledge used by nurses to inform their work

The social knowledge bridge between policy and case would include social and cultural aspects of working with individuals in need of healthcare taking into consideration the impact of wider policy issues on nursing knowledge and care. This should include engagement with other sectors such as council and social services, and the voluntary sector. In addition the social knowledge between policy and case should consider how policy (both national and local organisational policy) is interpreted through culture and environment. At present many national policy initiatives are broad allowing local implementation to factor specific nuances in relation to population need. Using the bridge in my model would enable this aspect of service design to be considered as a natural part of what comprises the work of nursing. The social knowledge bridges between case and patients and patient and person remain in line with those described by Liashenko and Fisher (1999). The former comprising knowledge in relation to other HCPs, organisation of care and appropriate person to undertake the role and the latter comprising social knowledge that goes beyond the boundaries of healthcare.

8.44 Research

As a result of the work in my thesis, research and evaluation of the above model would be required. Additional issues are raised which would benefit from further investigation. Firstly, an exploration of metrics on which to evaluate nursing roles such as the community matron role would be useful. In this way, 21st century nursing may be better understood and better seen. This could be considered in relation to process as well as, or instead of, outcome measures. Secondly, research to design, validate and test the implementation of case finding tools that will allow for the measurement of outcomes which reflect the qualitative aspects of work highlighted in this study is required. In so doing, the work undertaken by community matrons may be more visible. Thirdly, research into whether increasing visibility reduces service re-designs and therefore promotes embedding for new nursing roles such as that of community matron. Fourthly, I consider there is a need to research on the effects of roles being less visible. Within this I include exploration of work that occurs at the boundaries of the role, in relation to the emotional labour of nursing (and de-motivation). Finally, research into the subtleties and complexities of working in the community is required to make this work more visible to the wider healthcare community.

The recommendations should be considered in light of the study limitations which were presented in section 5.8. The lack of a robust data set to provide meaningful information on which to evaluate aspects of new nursing roles remains problematic. That conclusions and recommendations are drawn from a purposeful sample of participants, albeit across three areas, means that larger scale exploration may be required to ensure recommendations made are sound and will prove useful to improving visibility of new roles and their ability to embed.

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Appendix 1: Literature review prior to 2004, Hutt et al 2004

(References marked in reference list with *)

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Appendix 2: Executive summary of parent project

Randall, S., Barker, A., Thunhurst, C., Daly, G., and Mills, N. (2011a) *A Review of the Community Matron Service in the Heart of Birmingham Teaching Primary Care Trust*. Coventry University: Coventry

The then new role of the community matron was introduced as a consequence of the 2004 NHS Improvement Plan. It comprises the use of highly skilled clinical nurse specialists operating a system of case management. Although broad parameters for the role have been established, different models are to be found in practice.

A team from the Applied Research Group in Public Health from within the Faculty of Health and Life Sciences at Coventry University was commissioned to undertake a review of the operation of the Community Matron Service in the Heart of Birmingham Teaching Primary Care Trust {HoBtPCT}. The review had the following aim and objectives:

Aim:

To assess and evaluate the extent to which the Community Matron Service in Heart of Birmingham Teaching Primary Care Trust (HoBtPCT) has implemented case management approaches to care and the impact this has had on reduction in unnecessary hospital admissions, particularly amongst minority ethnic groups.

Objectives:

- Investigate the operation of the Community Matron Service in HoBtPCT
- Identify the extent to which Community Matrons have succeeded in implementing the nine elements of case management
- Assess the impact of the Community Matron role on patient journeys, particularly in respect of hospital admissions and re admissions
- The extent to which the role and case management have impacted on the qualitative experience of patients and carers.

This draft summary presents the evaluation team's findings and suggests a number of conclusions and recommendations.

Overall Findings:

Overall, we have found that the model of the Community Matron Service currently being implemented within HoBtPCT works well in respect of meeting the intended domains of case management. However, its effectiveness and impact are potentially compromised by contextual issues. The most critical of these may be summarised as a lack of understanding and a lack of engagement from working partners. Notwithstanding our general findings on the strength of the model being implemented, we have necessarily found areas of potential service improvement and have identified steps that could be taken to increase effectiveness both at an individual and at a zonal level.

In the course of this study we have subjected data derived from the Patients at Risk of Readmission (PARR) system to intensive scrutiny. We have had difficulty extracting the valuable information which is 'locked away' inside the PARR data set. More importantly, it is apparent

that these difficulties make it a less effective and unused tool for active case finding. Large numbers of individuals with long-term conditions who could be case managed are not. The need for service expansion should, therefore, be considered (see Appendix 15).

Previous studies have suggested that the Community Matron model can improve quality of care for the patient and quality of life for their carers and this is a finding that our own study would endorse. These studies have, however, produced no discernible evidence of impact when measured in terms of hospital admissions or length of in-patient stay. In contrast to previous studies, our initial detailed scrutiny of 12 patient journeys provided some a priori evidence of impact assessed against these metrics. . To test the overall impact of the service on admissions and length of stay exploration of a fuller data set was undertaken. A larger set of patient journeys was examined to explore encounters with health services before and after community matron intervention and, in order to allow for the natural trajectory in long term patient condition, to explore the differences in health service encounters between a sample of patients who had received a community matron intervention and a matched sample who had not. The earlier a priori findings were not confirmed. We would therefore conclude that, as with previous studies, we have not found generalised evidence of a reduction in hospital admission or length of patient stay.

Methodology:

Our findings have been derived through the use of a mixture of investigative methods. A literature review was undertaken to place the long-term conditions agenda in context and to review existing evidence of the effectiveness of community matrons in operating case management for patients with long-term conditions. This was followed by collection and analysis of original evidence derived from a range of qualitative and quantitative sources. Questionnaires, face to face interviews and focus groups were employed to elicit qualitative information from the Community Matrons themselves, from their patients, from the carers of their patients, and from their co-workers. The journeys of a sample of patients being case-managed by community matrons were tracked using data from the Patients at Risk of Re-hospitalisation (PARR) records. A much larger anonymised sample of community matron case-managed patients was derived from the PARR data set to look for variation in hospital attendance rates and in-patient bed days before and after patients' admission onto the community matron caseload. To allow for shifts in the underlying aetiology of patients case-managed by community matrons, these rates were compared with a matched comparison group of patients not case-managed by a community matron.

Specific Research Questions:

Investigate the operation of the Community Matron Service in HoBtPCT

Out of Hours Cover

In general terms, out of hours cover presents difficulties for patients and carers. It is noted, however, that this issue is not solely the domain of the Community Matron Service, but extends to out of hours GP cover, as well. It is recognised that the Community Matron Service is neither an emergency service nor reactive in purpose. However, in working towards keeping individuals at home when it is safe so to do, the lack of health care professionals who know the history of

this group of complex and vulnerable patients overnight and at weekends often means the only recourse of patients and carers is to dial 999. In order to reduce the numbers of patients with long-term conditions being admitted to hospital a 'whole systems approach' is required. Within the 'whole systems approach', there are many 'sub systems' of which the Community Matron Service is one. Other 'sub systems' which have been at the forefront of key informants thoughts in this evaluation are GPs, and particularly out of hours GP services, and the ambulance service. That all 'sub-systems' of workers do not appear to be working together to reduce hospital admissions affects substantially the Community Matron Service's ability to do so.

Consideration could be given to using telehealth and telemedicine as a means of improving communication between patients and key services, including the Community Matron Service. By having appropriate equipment depending on patient need, patients are able to send vital sign information through to health care staff as well as having a video consultation with health care professionals. In other parts of the country, the Community Matron Service has been able to prioritise patient visits according to up-to date information that is available to staff.

Number of different hospital/ community trusts in Birmingham

The Community Matron Service in HoB is complicated by the city of Birmingham presently being served by three acute hospital trusts, covering 6 different hospitals (since 10 June 2010 when Selly Oak and the old Queen Elizabeth hospitals amalgamated on one site). Although emergency admissions for HoB patients usually result in admission to City Hospital, if patients self refer they will pick the hospital of their choice. The resulting interface between acute and community services therefore leads to many individuals needing to be reminded repeatedly of the merits of the Community Matron Service, not least because of staff turnover in the acute sector. In addition, Birmingham is currently served by three Community Trusts: South Birmingham, Birmingham East and North (BEN) and HoB. Each has its own Community Matron Service working differently. Interviews with acute staff across the Acute/Hospital Trusts suggest that even when they are aware of the Community Matron Service, they are poor at distinguishing between the services of the Community Matron Service provided by each PCT.

Clarification of roles

Within some parts of Heart of Birmingham's Community Matron Service and the wider District Nursing Service there appears to be an element of role confusion between that of Community Matron and that of District Nurse. This is noticeable where Community Matrons have a District Nurse background, although it is noted to be at an individual level rather than service wide level. Where other staff have known a Community Matron previously as a District Nurse, this could allow boundaries to be blurred between the services and create confusion amongst GPs. For acute staff who have very little knowledge of community roles, interviews highlighted an identification of the role of the Community Matron with that of the District Nurse.

From the limited responses received from GPs, some wish to establish Community Matrons within a practice setting. In the current context of the move to GP commissioning, this might be seen as a welcome move with GPs wishing to establish Community Matrons within their practice setting. On the other hand, It could be considered that such a move would further fragment ways of working of the Community Matron Service, with the potential to lead to more confusion.

Identify the extent to which Community Matrons have succeeded in implementing the nine elements of case management

Based upon interviews with community matrons, secondary health care providers, district nurses, case managers, patients and family carers, and on our own observations and interpretations, the following findings emerged, in respect of each domain

Domains	
A	Advanced Clinical Nursing Practice
B	Leading Complex Care Co-ordination
C	Proactively Manage Complex Long Term Conditions
D	Managing Cognitive Impairment and Mental Wellbeing
E	Supporting Self Care, Self-management and Enabling independence
F	Professional Practice and Leadership
G	Identifying High Risk Patients, Promoting Health and Preventing Ill Health
H	Managing Care at the End of Life
I	Interagency and partnership working

Domains - Case Management Competences Framework (NHS Modernisation Agency & Skills for Health, 2005)

Domain A - Advanced Nursing Skills

The majority of Community Matrons reported having, or working towards, a degree or postgraduate educational qualification. However, the ability to implement advanced nursing skills varied across zones. This was, in part, affected by limited access to training and education, which had to be shared equally across individuals and zones. The Community Matrons who came into post early after the role's inception had considerable opportunities to develop advanced skills, but for those appointed later the opportunities were fewer. Although a framework for education is in place, clearer guidelines would be advantageous so that individuals were clear about employer expectation, personal requirements and timeframes for accessing education. A clear system of mentorship would also be on benefit to Community Matrons, particularly those who have less experience.

Skills in physical examination, prescribing and signposting were appreciated by patients and family carers, because it meant expert help can be provided at home, rather than attempting to access the GP. Some GP respondents questioned the level of clinical skills of Community Matrons. It is noted by the evaluation team that the role of Community Matron is that of a generic worker with knowledge across many disease pathways and with skills to access specialist knowledge from GPs, specialist nurses and hospital consultants as and when needed to supplement existing skills.

Domain B - Leading Complex Care Co-ordination

The consensus amongst Community Matrons was that this was a fundamental aspect of their role. There were indications that their ability to execute this aspect successfully was predicated on building strong communication links with allied services and professionals. Community

Matrons reported difficulty in making inroads with some allied services and stressed the time consuming nature of this aspect of their role. This could be reflected in them appearing to make few contacts in a day, as recorded on the PAS system (an electronic system for inputting patient contacts, used within HoBtPCT), which we suggest should be balanced against the level of resourcing, including time, needed to manage complex cases. Overall, this domain appears to be achieved by the majority of Community Matrons.

Domain C - Proactively Manage Complex Long Term Conditions

Proactive case management was largely discussed in terms of case finding, which varied across zones. Most Community Matrons received the majority of their referrals from a GP. The utilisation of PARR as a case finding tool varied. The majority of Community Matrons found the PARR data format difficult to decipher and, therefore, time consuming. Evidence suggests that Community Matrons are successfully achieving this aspect of their role, with patients having fewer Accident and Emergency attendances following their intervention. Many examples were given that showed the proactive nature of the role, which often required tenacity and 'thinking outside the box' to manage individuals with long-term conditions in a proactive manner. Again, for those community Matrons with less experience in the role, mentorship from a more experienced Community Matron would enable growth in confidence of the role.

Domain D - Managing Cognitive Impairment and Mental Well being

Most Community Matrons stressed their lack of training in supporting patients with cognitive impairment. The ability to manage patients with mental health issues varied across zones. Some Community Matrons felt better equipped to support patients than did others. The general consensus amongst Community Matrons was that more training was needed to improve their effectiveness. Similar anxieties and an inability to manage this group of patients were also noted by secondary care staff. It was also noted by both these sets of informants that services available to help individuals with cognitive impairment were often overwhelmed with referrals, reducing effectiveness.

The ability to meet the psycho-social needs of this vulnerable group of patients was highly valued by patients and carers and appeared to impact positively on physical health issues.

Domain E - Supporting Self Care, Self-management and Enabling independence

Confidence amongst Community Matrons was high when discussing their impact on patients in this area, despite some of the challenges that they faced. However, the interviews with secondary care did not reveal any noticeable impact of the Community Matron role in this area. Possible explanations for this may include the fact that the patient is acutely ill when admitted to hospital, so that their ability to self-manage is diminished, and time is needed to regain independence. This may be facilitated more quickly on return to their own home. Community Matrons report working to facilitate speedy discharge.

Within the literature, a common theme is that the Community Matron role can develop dependency-based relationships between Community Matrons and patients. Interviews with patients, family carers and the Community Matrons in HoBtPCT indicated that both patients and

staff had a clear understanding of the role and responsibilities of Community Matrons, enabling the implementation of strategies which promoted independence and the ability to make steps to manage exacerbations.

Domain F - Professional Practice and Leadership

Questions relating to leadership disclosed a distinct confusion regarding this domain. Most Community Matrons could not distinguish between leadership and management. It was however evident that the perception of leadership, as it related to this domain, varied across zones. The leadership ability of individual Community Matrons was, however, noted by colleagues both within the Community Matron Service and in secondary care. The varying levels of experience in the role of Community Matron may affect this. In addition, there also appear to be individual traits, with some individual Community Matrons demonstrating clear leadership attributes. Again, mentorship could have a positive impact on improving this aspect of the role.

Domain G - Identifying High Risk Patients, Promoting Health and Preventing Ill Health

Identification of high risk patients was often conducted through GP referrals using the PARR data. However, PARR data was not popular, as previously noted. Most Community Matrons claimed that it was up to three months out of date. It was suggested that, in view of this, timely intervention was difficult. Information from PARR also highlights that a large proportion of patients who meet the criteria for case management are not case managed. An expansion of the Community Matron Service, including greater skill mix, would allow such patients to be case managed with a view to reducing hospital admissions.

Skills and knowledge for health care promotion and ill health prevention varied across the zones. Some Community Matrons felt more confident and better equipped than others. This variation in confidence was related to the background of the individual Community Matrons. For example, Community Matrons with a practice nurse background were more familiar and comfortable with the health promotion role.

Domain H - Managing Care at the End of Life

Whilst managing care at the end of life evoked an emotional response from Community Matrons, discussions revealed that they were often faced with dilemmas relating to disease trajectory, resuscitation policies and communication around prognosis. Some Community Matrons felt better prepared to support patients and families than others. Clarification of their role in end of life care seemed to be required where palliative teams are already involved. Staff in acute care reported confusion surrounding the plethora of services available and also a frustration that patients were often admitted to hospital at end of life when hospitalisation was not appropriate for the individual.

Domain I - Interagency and partnership working

Discussions around this domain revealed pockets of excellent communication and joint working, particularly where a Discharge Liaison Nurse is employed. The use of case conferences showed success in getting key players around the table and was an example of good practice. It is, however, clear from some of the secondary care interviews that providers of some services do

not understand the role of the Community Matron. For patients and family carers, having a single point of contact via the Community Matron was seen as a major advantage in helping them to negotiate the myriad of services.

As noted above, effectiveness in this area would be improved if other services worked to reduce hospital admission whenever possible. An improved system of communication of those patients who are case managed across other services may be a start.

Assess the impact of the Community Matron role on patient journeys, particularly in respect of hospital admissions and re-admissions

Findings support reductions in hospital admission and readmission

Comparison of 13 patient journeys before and after referral to the Community Matron Service in HoB presented strong a priori evidence of a reduction in hospital admissions and/or re-admissions. This finding was based on qualitative accounts as well as an examination of PARR ++ data. In the light of these findings, and in view of the possible bias introduced through the process of patient selection, a larger analysis of anonymised PARR records was undertaken. This showed some small increases in the rates of hospital bed days used and hospital attendances after a Community Matron intervention. To allow for the effect of natural disease and care progression, the experience of patients being case-managed by a Community Matron was compared with a matched set of non case-managed patients. An increase in both measures remained; though all differences were of a non statistically significant magnitude.

Examination of the 13 patient journeys shows a subsequent reduction in PARR score. The active and intense case management by the Community Matrons is believed to have brought about this positive outcome. Reduction in PARR score may lead to discharge from the case load, but arguably by discharging patients from case management to no support would put this vulnerable group at risk of reduced stability. The introduction of a greater skill mix to include associate Community Matrons (or staff nurses) to oversee this lower-risk group would free up the Community Matrons to accept new referrals and maintain manageable caseloads, whilst also being available to manage new acute exacerbations in the previously stable group.

The extent to which the role and case management have impacted on the qualitative experience of patients and carers.

Carers

From the carers interviewed, a very positive view of the Community Matron Service within HoBPCT was observed. The main theme which emerged was the ability of the Community Matron to co-ordinate care. Key aspects mentioned were the value of having a single point of contact, organising respite care (which one carer describes as being like '*climbing Mount Everest*' prior to her mother being referred to the service), pulling aspects of health and social care together, organising care in a patient's own home and generally being a '*door opener*' for carers. The opportunity to speak to a Community Matron was also rated highly, especially when compared to GPs (issues of out of hours aside).

Patients

Patients interviewed also rated highly the service provided by Community Matrons. Their focus was different to that of carers. Patients rated very highly the Matrons' knowledge of them as individuals, and of their needs as a whole. This was in contrast to their view of medical consultants, who were perceived to be interested in aspects related to their specialism, rather than in all aspects of poor health and in the social situation which affected the patient. The evaluation team note that it would not be practical for all health service workers to have this wide ranging view of individual patients, but the role of Community Matron, in being a single point of contact for patients, is not only popular but also helps patients access high quality, timely care. Such benefits would be available to other health professionals if they were to contact the Community Matron. A more robust system of flagging patients who are case managed by a Community Matron may increase access for other health professionals and give them the opportunity to gain valuable information on cases through a single contact point.

In addition, the ability of Community Matrons to prescribe was seen as important by patients, in that they did not have lengthy waits prior to accessing their GP and could thus get timely treatment.

Other Areas of Potential Service Improvement.

As noted above, PARR data can prove to be a reliable way of finding cases, but not in its current form as received by the Community Matrons. Simplifying the data in order to meet the needs of the Community Matron referral criteria may allow a clear focus in case finding. During this evaluation the research team has simplified the very complex raw data into a meaningful form. The ability to see how useful this data can be when presented appropriately may engage the Community Matrons further. Identified cases can then be discussed with GPs and other health care professionals to explore the suitability of the patient for case management. The audio diaries kept by Community Matrons identified issues of work practice which were difficult to capture through existing methods of collecting workload data. These included psycho-social care, advocacy, and barriers to greater efficiency. Improving the capture of such data has the potential to increase the understanding of the service by other health care professionals.

Recommendations

Consideration has been given to these in light of Quality (Q), Innovation (I), Productivity (Prod), Prevention (Prev) (QIPP agenda)

Investigate the operation of the Community Matron Service in HoBtPCT:

1. Consider a change in working patterns to reflect a more robust out of hours service, across other key services in order to support the efforts of the Community Matron service in keeping individuals out of hospital. (QIPP)
2. Examine whether a single, pan-Birmingham, working policy and set of referral criteria for the Community Matron service would aid effectiveness (QIPProd)
3. Make a strong distinction between the role of the Community Matron and that of the District Nurse, seeing them as symbiotic to each other rather than mutually exclusive.(Q)

Identify the extent to which Community Matrons have succeeded in implementing the nine elements of case management:

1. Develop a strategy to engage GPs in awareness raising of the benefits of having a Community Matron Service ([Q PP](#))
2. Draw up transparent education and training requirements to ensure that Community Matrons have appropriate knowledge and skills which are effective and remain up to date. This may include formal mentorship. A framework of acknowledged skills and a rolling programme of education would allow benchmarking and evaluation. ([Q Prod](#))
3. Ensure that there is parity across zones in the levels of knowledge, skill and experience. ([Q P P](#))
4. Build on the current aspects of leadership in order to provide appropriate support and positively affect group dynamics within the Community Matron service's zones. ([Q I P P](#))
5. Ensure the continued high visibility of the service, particularly in acute settings ([Q Prod](#))
6. Establish a pan-Birmingham approach to end of life care to reduce confusion and duplication ([Q I P P](#))
7. Establish a working group (including community, acute and ambulance services) to explore common policy around community 'do not actively resuscitate' policies ([Q I Prev](#))
8. Maintain the autonomous role of Community Matron to ensure that the benefits of time spent with patients is protected as opposed to being taken up by managing other team members (in order to maintain NHS benchmarking targets Aug 2010) ([Q P P](#))

Assess the impact of the Community Matron role on patient journeys, particularly in respect of hospital admissions and re admissions

1. Continue with the use of a case finding tool, but consider adopting the West Midlands Risk Stratification Tool([Q, Prev](#))
2. Investigate procedures for the routine collection of 'soft' data on working practices so as to increase the understanding of the service by other health care professionals.
3. Increase the number of Community Matrons so that patients who are eligible for case management (PARR high and PARR medium) can be case managed, thereby reducing the likelihood of hospital admission or re-admission (as per Appendix 15) (QPP)
4. Consider extending the skill mix to manage patients with reducing PARR scores, without reducing the number of Community Matrons ([QIPP](#))
5. Explore whether a system of flagging patients who attend A&E could further enhance the impact of Community Matron case management on reducing admissions and re-admissions. (QPP (QPP))
6. Explore further the mechanisms for sharing information regarding case managed individuals amongst services; other services could include out of hours (OOH) GP services, the ambulance service and A&E staff (QIPP)
7. Investigate and consider the use of telehealth and telemedicine as means of assessing need for admission to hospital, especially out of hours. Such techniques can include vital signs data and video consultation being available to OOH staff (QIPP)

The extent to which the role and case management have impacted on the qualitative experience of patients and carers.

1. Continue to listen to patients and carers about this key service (Q)

The Community Matron Perspective

Our report was shared with community matrons at a draft stage in its production. The recommendations were broadly endorsed by the service with the observation that they had “enjoyed taking part in the research and very much feel it has been a thorough and worthwhile exercise that has reflected the service honestly whilst giving thoughts/a vision for further improvement”. Observations on specific recommendations were:

“At present the (PARR) tool isn’t well received due to time restrictions and the fact that PARR is not live data.”

“Rapid response including a multi banded team of nurses so that acute and planned visits could be carried out”

“The service totally agrees that a Community Matron in a GP surgery would add further confusion to the role and take away the autonomy of the matrons”

“Some case management services around the country have directly employed a registered mental nurse to further support patients and staff with management of patients from this group”

“A strategy (to engage GPs) has been in place for over two years now and the service has made huge improvements in working relationships with GP colleagues, however as the research team found some difficulties in engaging GPs still exist.”

“End of life care in Birmingham is already an established city wider service”

Concluding Comments

A brief summary of our findings would be that we believe that we have provided evidence to suggest that the model of the community matron service operating within HoB PCT to a very large degree implements the domains of nurse-led case management as conceived in the formulation of this role. Further, we believe that this is already proving to be beneficial to both patients and carers. In addition, we have identified a number of areas where we believe further development of this model is possible in the expectation that even greater benefits may be accrued.

We have, however, also noted that there are changes pending to the HoB community matron model. We would observe that such changes might pose a risk to the full embedding of the current model which we feel is still in an embryonic state. Proposed changes also pose a risk to the service’s ability to accumulate sufficient experience of the current model to demonstrate whether the a priori evidence might grow to become evidence of a substantive and statistically significant nature.

Appendix 3: Parent project responsibilities

	Sue Randall Senior Researcher	Guy Daly	Colin Thunhurst	Natalie Mills	Annette Barker Research Assistant
Bid writing	x	x	x	x	
Literature review: Case management	x				
Lit review: Community Matrons					x
Ethics submission: information sheets, consent forms, IRAS, R&D	x				
Data collection: Qualitative interviews	x				
PARR data					x
Comparing patient journeys	x				x
Analysis of data: qualitative	x				
Analysis of data: Quantitative (PARR)			x		x
Periodic reports for funder's reference group	x				
Report Writing:	X (qual)	X (revisions)	X (revisions)		X (quan)
Dissemination: conferences	x				

For PhD, the context was expanded, including the theoretical expansion using Liaschenko. The literature review was re-written and updated. Additional explanation of the use of mixed methods was incorporated. An ethics request was re-submitted, along with R&D. Re-approval was gained. Additional geographical areas were included and further qualitative data collected.

The PARR data was re-examined. This was done using SPSS 20 (in the original project, excel had been used). All data was re-analysed and interpreted in light of PhD research question.

Appendix 4: Ethics approvals*

*Note, the title of this thesis is based on the findings and so differs from that used in the request for ethical approval



**National Research Ethics Service
NRES Committee West Midlands - Coventry & Warwickshire**

Prospect House
Fishing Lane Road
Enfield
Redditch
B97 6EW

Telephone: 01527 682532
Facsimile: 01527 682540

Date: 14 September 2011

Mrs Sue Randall
Faculty of Health & Life Sciences
Department of Nursing & Midwifery
Coventry University
CV1 5FB

Dear Mrs Randall

Study title: An exploration of the effects of policy on the community
matron role
REC reference: 11/WM/0244

Thank you for your letter dated 12 September 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Committee held on 12 September 2011. A list of the members who were present at the meeting is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering Letter		12 September 2011
Interview Schedules/Topic Guides	1	25 March 2011
Investigator CV		13 July 2011
Letter from Sponsor		13 July 2011
Letter from Statistician		
Other: Summary CV for supervisor (Gill Furze)		12 July 2011
Other: Topic Guide: Question areas for GPs	1	25 March 2011
Other: Topic Guide: Question areas for commissioners/provider arm managers	1	25 March 2011
Other: Topic Guide: Face to Face Patient Questionnaire	1	25 March 2011
Other: Topic Guide: Face to Face Carer Questionnaire	1	25 March 2011
Other: Letter from HOB Angela Knight Jackson		22 June 2011
Other: Certificate of Employers' Liability Insurance[a]		
Participant Consent Form: Consent Form A: Patient (previous study)	1	21 March 2011
Participant Consent Form: Consent Form B: Patient (new)	1	21 March 2011
Participant Consent Form: Consent Form C: Community Matron (previous)	1	21 March 2011
Participant Consent Form: Consent Form D: Community Matron (new)	1	21 March 2011
Participant Consent Form: Consent Form E: Healthcare Employees (new)	1	21 March 2011
Participant Consent Form: Consent Form F: Carers (new)	1	21 March 2011
Participant Consent Form: Consent Form G: Carers (previous)	1	21 March 2011
Participant Information Sheet: Community Matron's Information sheet (new)	2	20 March 2011
Participant Information Sheet: Health Care Employees' Information Sheet	1	21 March 2011
Participant Information Sheet: Carers [previous participants]	2	06 September 2011
Participant Information Sheet: Patients [previous participants]	2	06 September 2011

Participant Information Sheet: Patients [new participants]	3	06 September 2011
Participant Information Sheet: Carers' [New participants]	3	06 September 2011
Protocol	1	20 March 2011
REC application	IRAS 3.1	13 July 2011
Referees or other scientific critique report		16 June 2011

Statement of compliance

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.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

11/WM/0244	Please quote this number on all correspondence
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With the Committee's best wishes for the success of this project.

Yours sincerely


 Dr Helen Brittain
 Chair

Email: [REDACTED]

Enclosures: "*After ethical review – guidance for researchers*" [SL-AR2]

Copy to: Professor Gill Furze
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National Research Ethics Service
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Date: 26 September 2011

Mrs Sue Randall
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CV1 5FB

Personal contact details have been removed from the electronic version of this thesis.

Dear Mrs Randall

Full title of study: An exploration of the effects of policy on the community
matron role
REC reference number: 11/WM/0244

Thank you for your letter dated 23 September 2011. I can confirm the REC has received the documents listed below. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

Document	Version	Date
Covering Letter		23 September 2011
Participant Consent Form: A: Patient	2	12 September 2011
Participant Consent Form: B: Patient	2	12 September 2011
Participant Consent Form: F Carers [new]	2	03 September 2011
Participant Consent Form: G: Carers [previous]	2	12 September 2011

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

11/WM/0244

Please quote this number on all correspondence

Yours sincerely

Mrs Rosa Downing
Committee Co-ordinator
E-mail: [REDACTED]

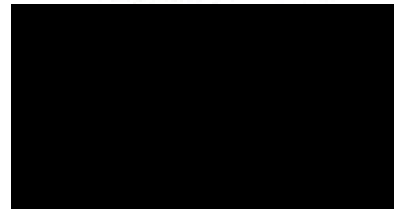
*This Research Ethics Committee is an advisory committee to West Midlands Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorates within the Research Ethics
Committees in England*

Copy to: Professor Gill Furze ✓
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Mrs Sue Randall
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21 October 2011

Personal contact details have been removed
from the electronic version of this thesis.

Dear Sue

Re: An Exploration of the effects of policy on the community matron role: Essence of Nursing

R&D Approval No.: 21101101

Project Reference: SWH089

I can confirm that the R&D Department has reviewed the above project and is happy to grant Trust approval.

Your research activity is now covered by NHS indemnity as set out in HSG (96) 48, and your trial has been entered into the Trusts' database.

All research must be managed in accordance with the requirements of the Department of Health's Research Governance Framework (RGF) and to ICH-GCP standards. Your responsibilities are set out in the attached agreement.

The Trust employs the services of an external organisation to monitor 10% of all projects on an annual basis. You are contractually obliged to comply with the requests of this organisation as they have the authority to audit your site file at any time, in line with the Research Governance framework.

If you have any queries relating to R&D, please do not hesitate to contact me. The Trust wishes you success with your research.

Yours sincerely

A handwritten signature in blue ink that reads "Williams".

Research Manager

Enc: Sponsorship and responsibilities agreement





Mrs Sue Randall
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Friday, 04 November 2011

NHS National Institute for Health Research

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NHS PERMISSION FOR RESEARCH

NHS Permission for your research study has been granted by the BBC CLRN RM&G Consortium Office on behalf of the BBC CLRN RM&G Consortium Trusts. The Investigator named in this letter has permission to undertake the following research in the NHS Trust(s) and Research Site(s) identified below:

Original Date NHS Permission issued: 04.11.2011

Updated Date NHS Permission issued: N/A

Research Reference Numbers:	IRAS Code: 78052
	Consortium Ref.: BCHCTCom288.78052
	REC Ref: 11/WM0244
Project Title:	An exploration of the effects of policy on the community matron role
Date NHS Permission for Research Ends:	16.12.2013
Chief Investigator:	Mrs Sue Randall
Chief Investigator Employer:	Coventry University
Sponsor:	Coventry University
Funder & Funding amount:	Heart of Birmingham Teaching PCT £92000

NHS Trust Registered:	Local Collaborator:	Research Site:	Date NHS Permission issued:
Birmingham Community Healthcare NHS Trust (BCHCT)	Mrs Vikki Williams	BCHCT	04.11.2011
Trust Service/Directorate:	Adults and Community Division		

HR Agreement:	Issued:	Yes		
	Total Letters of Access (LoA) for non-NHS Staff issued:	01		
	Total Letters of Access (LoA) for NHS Staff issued:	00		
	Total Honorary Research Contracts (HRC) issued:	00		
Issued to:	HR Agreement:	Local Research Manager:	NHS Trust:	Date of Issue:
Mrs Sue Randall	LoA for Non-NHS Staff	Mrs Sue Randall	BCHCT	04.11.2011
Researcher(s) must abide by the governance arrangements specified by their NHS Local Research Manager and described in their LoA/HRC				

Director: Professor Robert Stockley
Hosted by: University Hospitals Birmingham NHS Foundation Trust

The Birmingham and the Black Country Comprehensive Local Research Network is part of the NIHR Clinical Research Network, which supports research to make patients, and the NHS, better

Conditions of NHS Permission

NHS Permission is given provided that you comply with the conditions described in the attached document: **Standards Conditions of NHS Permission for Research**. You are advised to read the conditions carefully as failure to comply with these conditions may invalidate your NHS Permission granted by the RM&G Consortium.

Research Investigators are required to share the learning from research and provide the BBC CLRN RM&G Consortium with:

- The literature review from the research protocol.
- Interim findings from the research, when available.
- A final report or summary of the research, highlighting where appropriate any findings specific to the BBC CLRN RM&G Consortium Trusts.

Please email this information directly to the BBC CLRN RM&G Consortium Office using the following address: consortium.rmg@uhb.nhs.uk

If you require any further assistance, please contact the RM&G Consortium Office stating your Consortium Ref: **BCHCTCom288.78052**.

We wish you success on completing your research.

Yours Sincerely,



Susie Harrison
BBC CLRN RM&G Operational Manager (Consortium)
BBC CLRN RM&G Consortium

Documents Enclosed:

1. NHS Permission Letter 04.11.2011
2. RM&G Consortium Standard Conditions of NHS Permission for Research
3. Non-NHS Letter of Access issued to Mrs Sue Randall for BCHCT

Scanned Copy of Documents sent to:

Mrs Sue Randall - Chief Investigator & Letter of Access holder
Prof Gill Furze - Academic Supervisor & Sponsor's Contact Point
Mrs Viki Williams - Local Collaborator & Local Research Manager for BCHCT
Coventry University HR Department - Letter of Access Holder(s) c/o Academic Supervisor
Clive Thurstfield - R&D Lead for BCHCT c/o PA
Tracey Phillips - Trust Divisional R&D lead for BCHCT
Karen Fields - HR Lead for BCHCT

West Midlands (South) Comprehensive Local Research Network
Fourth Floor, West Wing (ACF40002)
University Hospitals Coventry & Warwickshire NHS Trust
University Hospital
Clifford Bridge Road
Coventry
CV2 2DX

December 7th 2011

Mrs Sue Randall
Faculty of Health & Life Sciences
Department of Nursing & Midwifery
Coventry University
Priory Street
CV1 5FB

Dear Mrs Randall,

Project Title: *An exploration of the effects of policy on the community matron role.*

R&D Ref: PAR200911

REC Ref: 11/WM/0244

I am pleased to inform you that the R&D review of the above project is complete, and the project has been formally approved to be undertaken at Coventry and Warwickshire Partnership NHS Trust. Your research activity is now covered by NHS indemnity as set out in HSG (96) 48, and your trial has been entered onto the Trust's database.

The following documents were reviewed:

Document	Version	Date
NHS R&D Application Form		78052/250002/14/94
NHS Site Specific Information Form		78052/252281/8/503/128883/224137
REC Favourable Opinion Letter		September 14 th 2011
Protocol	V1	March 20 th 2011
Participant Information Sheet; Patients Information Sheet	V3	September 6 th 2011
Participant Information Sheet; Carers Information Sheet	V3	September 6 th 2011
Participant Information Sheet Community Matrons Information Sheet (new)	V2	March 20 th 2011
Participant Information Sheet; Health Care Employees Information Sheet	V1	March 21 st 2011
Consent form A; Patient	V2	September 12 th 2011
Consent form D; Community Matron (new)	V1	March 21 st 2011
Consent form E; Healthcare Employees	V1	March 21 st 2011

Participant Consent form: F	V2	September 3 rd 2011
Face to face Patient Questionnaire	V1	March 25 th 2011
Face to face Career Questionnaire	V1	March 25 th 2011
Question Areas for Commissioners/provider arm managers	V1	March 25 th 2011
Question areas for GPs	V1	March 25 th 2011
Interview Schedules: Individual community matrons	V1	March 25 th 2011
REC Favourable Opinion Letter		September 26 th 2011

Your responsibilities are set out in the attached agreement, which must be signed and returned to the R&D Office. You should keep a copy for your records.

All research must be managed in accordance with the requirements of the Department of Health's Research Governance Framework (RGF) and to ICH-GCP standards. In order to ensure that research is carried out to these standards, the Trust employs the services of an external monitoring organisation to provide assurance. Your study may be randomly selected for audit at any time, and you must co-operate with the auditors.

The duration of Trust approval extends to the date specified in the R&D application form. Action may be taken to suspend Trust approval if the research is not run in accordance with RGF or ICH-GCP standards, or following recommendations from the auditors. Research must commence within two years of the REC approval date and within six months of NHS Permission.

I wish you well with your project. Please do not hesitate to contact me should you need any guidance or assistance.

Yours sincerely



Rebecca Steele
Research & Development Facilitator

Enc: PI Agreement

Cc: Professor Gill Furze, Academic Supervisor
Mrs Lesley Williams, Head of Community Services Pathway Coventry & Warwickshire NHS Partnership Trust.

Appendix 5: Audio diary instruction sheet

Your Personal Journey – The Audio Diary

We would like you to record snap shots of your working life. This is a great opportunity to tell us about events in your working day especially those that you feel are not recognised as important.

We would like you to carry the Dictaphone with you when you are out and about and tell us about examples of the care that you give. We are particularly interested in the following

- Partnership working – eg working with other agencies and colleagues outside your service
- Leading and co-ordinating care
- Preventing unnecessary admissions to hospital
- Instigating appropriate admissions to hospital
- Supporting patients and relatives in end of life care situations
- Any event that you feel reflects the heart of what you do as a Community Matron
- Overcoming difficult situations
- If you've spent a number of hours with a patient and their carers then tell the Dictaphone
- The type of health education/information that you do
- How you feel about the care that you give

You will have the Dictaphone for 10 working days. **Be mindful of confidentiality.**

Using the Dictaphone

Switching on

Hold the device in the upright position, so that the screen is facing you. On the right side of the device towards the bottom is a slider button. Above it reads **"power"** with an arrow pointing towards the left. Slide the button towards the left and the machine will come on. The words **"system check"** will appear on the screen when you do this. You will then notice that **"Folder A"** appears at the top left of the screen and the device is ready to use. There is a voice guide built into the device which we have left active.

Recording your entries

Press the **record button**, on the right side of the device, once to record. Press it twice to pause recording. Press it again to resume recording. Press the **stop button** to stop recording.

Playback

You can listen to what you have recorded by pressing the **play button**. Using this buttons will not affect your recordings in any way.

How entries are identified

Each entry will be given a number eg **01/01** or **03/03** and will continue to be stored in Folder A until that folder is full. The device will then take you into Folder B. If you need to add anything to any of the entries that you made previously you can tell us by saying " this next comment relates to (the number of the entry you would like to refer to)"

What if you make a mistake?

You can erase entries by pressing the erase button. The screen will flash up two options “erase” and “cancel”. Use the the **+** or **–** (top and bottom of the circle of keys) keys to go up or down through the options and then press **ok**, which is the central button.

Switching the machine off.

Slide the power button to the left again. It will make a noise and the graphics will disappear.

Thank you.

Appendix 6: Participant Information Sheets



Patient Information Sheet (previous participants)

An Exploration of the Role of Policy on the Community Matron Role

Part 1

In 2009, you were invited to take part in a research study titled Effectiveness of Community Matrons in Case Management and Prevention of Hospital Admissions. After reading an information sheet like this dated 20/3/2009 version 1 you signed a consent form agreeing to take part, dated 20/3/2009 version 1.

This information sheet explains that the data you provided in the form of an interview is requested for re-analysis in answer to a new study which builds on the one you took part in previously. The data previously provided will be used in a doctoral thesis which seeks to explore the essence of nursing through the role of the community matron.

Before you decide whether to consent to this additional use of the data you have already provided, 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 other members of your family, if you wish. Part 1 tells you the purpose of the study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study and gives details of who to contact for further details.

Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

At a time when a growing number of people have long-term conditions, it is important that consideration is given to how people with long-term conditions can best be cared for, in order for their lives and those of their carers to be as good as possible. The purpose of this study is to explore the essence of nursing through the role of community matron. It also wants to consider if hospital admissions may have been prevented.

In the study we want to:

- Examine the benefits to people living with long-term conditions of having access to services including Community Matrons

- Consider the benefits to health care organisations (community & acute) of the Community Matron role, in particular case management.
- Consider implications for practice, policy, education and research in the future

Why have I been chosen?

You have been chosen because you previously spoke to me as part of the study mentioned on page 1 and had received care from a community matron as a patient.

Do I have to take part?

No, the decision to allow the further use of data provided previously is entirely yours. You may refuse. You may of course withdraw from the study all together at any time. If you decline to take part in the study, or if you decide to withdraw you will not be asked for your reasons. It will not affect your care in any way.

What will I have to do, if I take part?

I will ask you to sign a new consent form which confirms that you have read this sheet and agree to the further analysis of information already provided. This may include medical records about you, which you agreed to let me look at last time.

What are the possible benefits of taking part?

By taking part you have an opportunity to influence the outcome of the study and ensure that a clear picture of what it is like to have a Community Matron. It may influence future education, professional practice and care of other people with long-term conditions.

What are the possible risks of taking part?

You might feel worried about my request, but the information you have already given has helped a lot. Not wanting to have your data re-examined will not affect your care in any way.

The researcher (Sue Randall) will try to answer any concerns you have but you can also get further advice from the Patient Advice and Liaison Services (PALS). Their telephone number is: 0121 224 4725 or by e-mail: pals@hobtpct.nhs.uk

What happens when the research study stops?

All tapes of individual discussions will be destroyed. All information on you will also be destroyed. We will keep the transcripts of what has been said, but use a descriptor instead of people's real names. These transcripts will be kept at Coventry University until the final thesis is accepted. If I plan to change this I will seek your consent.

Where can I get support and make complaints?

If taking part in this study has raised issue that you would like to discuss further you could contact the Patient Advice and Liaison Services (PALS). Their telephone number is: 0121 224 4725; or by e-mail: pals@hobtpct.nhs.uk Or contact Sue Randall on [REDACTED]

Coventry University has public liability and professional indemnity insurance to cover negligent harm. In addition, where appropriate, honorary contracts will ensure inclusion of non-University personnel working on the research to be included. University staff will have honorary contracts with the NHS institution to include them within the NHS liability insurance.

Will my taking part in this study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2

All information, which is collected during the course of the study, will be kept strictly confidential unless to do so would breach the Nursing and Midwifery Code of Conduct (NMC 2008). Any information stored about you will have your name removed so that you cannot be recognised. All personal information will be stored in a locked filing cabinet in a locked room at Coventry University.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time without penalty. Any data already collected will still be used to inform the study, but will be anonymised.

What if there is a problem?

Any complaint about the way you have been dealt with during the study will be addressed. If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions, and to resolve the matter. Failing this, you may wish to contact the Coventry University Ethics Committee chair, Professor Ian Marshall, in writing at AB122, Coventry University, Priory Street, Coventry CV1 5FB, or by telephone on [REDACTED]

In the event of a complaint relating to the NHS Trust, you should follow the usual NHS Trust complaints procedure.

Will my taking part in this study be kept confidential?

Data will be collected through focus group and interview . It will be anonymised and stored in a locked cabinet in a key code protected room, or on a password protected computer. It will be retained until the final thesis is accepted, at which point any data will be securely destroyed.

What will happen to the results of the research study?

If applicable, results will be incorporated into existing training and if necessary new training will be produced to fill any gaps, subject to funding. It will also be shared with relevant agencies including local and regional special interest groups.

Conference papers will be submitted to appropriate forums to inform practitioners at a national level. The researcher will submit papers for publishing the results in relevant professional journals, in order to ensure wide dissemination to the target audience. A sheet of key findings will be produced for participants of the study.

Who is organising and funding the research?

This study is in fulfilment of a PhD in Nursing, Midwifery & Healthcare and is being undertaken at Coventry University. It is building on previous research which was funded by Heart of Birmingham teaching Primary Care Trust. This part of the study has no funding.

Who has reviewed the study?

This study will be peer reviewed at Coventry University and ethically approved by an appropriate research ethics committee (REC)

Contact for Further Information

Sue Randall,

Coventry University, Priory Street, Coventry, CV1 5FB,

Tel [REDACTED] Mob [REDACTED] or email [REDACTED]

Thank you for considering your involvement in this study

[The second copy of this information sheet should be attached to your copy of the signed consent form]

Carers' Information Sheet (previous participants)

An Exploration of the Role of Policy on the Community Matron Role

Part 1

In 2009, you were invited to take part in a research study titled Effectiveness of Community Matrons in Case Management and Prevention of Hospital Admissions. After reading an information sheet like this dated 20/3/2009 version 1 you signed a consent form agreeing to take part, dated 20/3/2009 version 1.

This information sheet explains that the data you provided in the form of an interview is requested for re-analysis in answer to a new study which builds on the one you took part in previously. The data previously provided will be used in a doctoral thesis which seeks to explore the essence of nursing through the role of the community matron.

Before you decide whether to consent to this additional use of the data you have already provided, 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 other members of your family, if you wish. Part 1 tells you the purpose of the study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study and gives details of who to contact for further details.

Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

At a time when a growing number of people have long-term conditions, it is important that consideration is given to how people with long-term conditions can best be cared for, in order for their lives and those of their carers to be as good as possible. The purpose of this study is to explore the essence of nursing through the role of community matron. It also wants to consider if hospital admissions may have been prevented.

In the study we want to:

- Examine the benefits to people living with long-term conditions of having access to services including Community Matrons

- Consider the benefits to health care organisations (community & acute) of the Community Matron role, in particular case management.
- Consider implications for practice, policy, education and research in the future

Why have I been chosen?

You have been chosen because you previously spoke to me as part of the study mentioned on page 1 and had a relative who received care from a community matron.

Do I have to take part?

No, the decision to allow the further use of data provided previously is entirely yours. You may refuse. You may of course withdraw from the study all together at any time. If you decline to take part in the study, or if you decide to withdraw you will not be asked for your reasons. It will not affect the care that your relative receives in any way.

What will I have to do, if I take part?

I will ask you to sign a new consent form which confirms that you have read this sheet and agree to the further analysis of information already provided.

What are the possible benefits of taking part?

By taking part you have an opportunity to influence the outcome of the study and ensure that a clear picture of what it is like to have a Community Matron. It may influence future education, professional practice and care of other people with long-term conditions.

What are the possible risks of taking part?

You might feel worried about my request, but the information you have already given has helped a lot. Not wanting to have your data re-examined will not affect the care that your relative receives in any way.

The researcher (Sue Randall) will try to answer any concerns you have but you can also get further advice from the Patient Advice and Liaison Services (PALS). Their telephone number is: 0121 224 4725 or by e-mail: pals@hobtpct.nhs.uk

What happens when the research study stops?

All tapes of individual discussions will be destroyed. All information on you will also be destroyed. We will keep the transcripts of what has been said, but use a descriptor instead of people's real names. These transcripts will be kept at Coventry University until the final thesis is accepted. If I plan to change this I will seek your consent.

Where can I get support and make complaints?

If taking part in this study has raised issue that you would like to discuss further you could contact the Patient Advice and Liaison Services (PALS). Their telephone number is: 0121 224 4725; or by e-mail: pals@hobtpct.nhs.uk

Or contact Sue Randall on [REDACTED]

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Will my taking part in this study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2

All information, which is collected during the course of the study, will be kept strictly confidential unless to do so would breach the Nursing and Midwifery Code of Conduct (NMC 2008). Any information stored about you will have your name removed so that you cannot be recognised. All personal information will be stored in a locked filing cabinet in a locked room at Coventry University.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in part 2 before making any decision.

Part 2**What will happen if I don't want to carry on with the study?**

You are free to withdraw from the study at any time without penalty. Any data already collected will still be used to inform the study, but will be anonymised.

What if there is a problem?

Any complaint about the way you have been dealt with during the study will be addressed. If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions, and to resolve the matter. Failing this, you may wish to contact the Coventry University Ethics Committee chair, Professor Ian Marshall, in writing at AB122, Coventry University, Priory Street, Coventry CV1 5FB, or by telephone on [REDACTED]

In the event of a complaint relating to the NHS Trust, you should follow the usual NHS Trust complaints procedure.

Will my taking part in this study be kept confidential?

Data will be collected through focus group and interview . It will be anonymised and stored in a locked cabinet in a key code protected room, or on a password protected computer. It will be retained until the final thesis is accepted, at which point any data will be securely destroyed.

What will happen to the results of the research study?

If applicable, results will be incorporated into existing training and if necessary new training will be produced to fill any gaps, subject to funding. It will also be shared with relevant agencies including local and regional special interest groups.

Conference papers will be submitted to appropriate forums to inform practitioners at a national level. The researcher will submit papers for publishing the results in relevant professional journals, in order to ensure wide dissemination to the target audience. A sheet of key findings will be produced for participants of the study.

Who is organising and funding the research?

This study is in fulfilment of a PhD in Nursing, Midwifery & Healthcare and is being undertaken at Coventry University. It is building on previous research which was funded by Heart of Birmingham teaching Primary Care Trust. This part of the study has no funding.

Who has reviewed the study?

This study will be peer reviewed at Coventry University and ethically approved by an appropriate research ethics committee (REC)

Contact for Further Information

Sue Randall,

Coventry University, Priory Street, Coventry, CV1 5FB,

Tel [REDACTED] Mob [REDACTED] or email [REDACTED]

Thank you for considering your involvement in this study

[The second copy of this information sheet should be attached to your copy of the signed consent form]

Patient Information Sheet (new participants)

An Exploration of the Effects of Policy on the Community Matron Role

Part 1

You are being invited to take part in a research study, which will provide data for doctoral thesis. Before you decide whether or not to participate, 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 other members of your family, if you wish. Part 1 tells you the purpose of the study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study and gives details of who to contact for further details.

Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

At a time when a growing number of people have long-term conditions, it is important that consideration is given to how people with long-term conditions can best be cared for, in order for their lives and those of their carers to be as good as possible. The purpose of this study is to explore the essence of nursing through the role of community matron. It also wants to consider if hospital admissions may have been prevented.

In the study we want to:

- Examine the benefits to people living with long-term conditions of having access to services including Community Matrons
- Consider the benefits to health care organisations (community & acute) of the Community Matron role, in particular case management.
- Consider implications for practice, policy, education and research in the future

Why have I been chosen?

You have been chosen because you are receiving services from a community matron, either as a patient or as the family carer of a patient.

Do I have to take part?

No, the decision to take part is entirely yours. You may also refuse to answer any questions. You may of course withdraw from the study all together at any time. If you decline to take part in the study, or if you decide to withdraw you will not be asked for your reasons. It will not affect your care in any way.

What will I have to do, if I take part?

The study will involve you signing a consent form, being interviewed by a researcher, who is a nurse. This will take an hour. If you don't feel well on the day of the interview you can cancel. If you start the interview, but then feel unwell, the interview can be stopped. This will not affect the care you receive in any way.

Medical records about you may be reviewed by the research team.

The purpose of the study is not to make judgements about the clinical practice of your Community Matron, but rather to explore how you see the role of community matron, and to consider when admissions to hospital have been avoided, or discharges from hospital facilitated speedily.

What are the possible benefits of taking part?

By taking part you have an opportunity to influence the outcome of the study and ensure that a clear picture of what it is like to have a Community Matron. It may influence future education, professional practice and care of other people with long-term conditions.

What are the possible risks of taking part?

You might feel worried that your answers will affect the care you receive. This will not happen.

You may feel unwell during the course of the interview. The interview can be stopped without affecting any care you receive.

The researcher (Sue Randall) will try to answer any concerns you have but you can also get further advice from the Patient Advice and Liaison Services (PALS). If you live in Warwickshire, their telephone number is: 0845 423 8903 or by e-mail: pals@warkpct.nhs.uk Or if you live in Coventry their number is 024 7624 6002 or by e mail: PALS@coventrypct.nhs.uk

What happens when the research study stops?

All tapes of individual discussions will be destroyed. All information on you will also be destroyed. We will keep the transcripts of what has been said, but use a descriptor instead of people's real names. These transcripts will be kept at

Coventry University until the final report is accepted. If I plan to change this I will seek your consent.

Where can I get support and make complaints?

If taking part in this study has raised issue that you would like to discuss further you could contact the Patient Advice and Liaison Services (PALS). Their telephone number is: Warwickshire 0845 423 8903 ; or by e-mail: pals@warkpct.nhs.uk OR Coventry 024 7624 6002 or by e mail: PALS@coventrypct.nhs.uk

Or contact Sue Randall on [REDACTED]

Coventry University has public liability and professional indemnity insurance to cover negligent harm. In addition, where appropriate, honorary contracts will ensure inclusion of non-University personnel working on the research to be included. University staff will have honorary contracts with the NHS institution to include them within the NHS liability insurance.

Will my taking part in this study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2

All information, which is collected during the course of the study, will be kept strictly confidential unless to do so would breach the Nursing and Midwifery Code of Conduct (NMC 2008). Any information stored about you will have your name removed so that you cannot be recognised. All personal information will be stored in a locked filing cabinet in a locked room at Coventry University.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time without penalty. Any data already collected will still be used to inform the study, but will be anonymised.

What if there is a problem?

Any complaint about the way you have been dealt with during the study will be addressed. If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions, and to resolve the matter. Failing this, you may wish to contact the Coventry University Ethics Committee chair, Professor Ian Marshall, in writing at AB122, Coventry University, Priory Street, Coventry CV1 5FB, or by telephone on [REDACTED]

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What will happen to the results of the research study?

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Who is organising and funding the research?

This study is in fulfilment of a PhD in Nursing, Midwifery & Healthcare and is being undertaken at Coventry University. It is building on previous research which was funded by Heart of Birmingham teaching Primary Care Trust. This part of the study has no funding.

Who has reviewed the study?

This study will be peer reviewed at Coventry University and ethically approved by an appropriate research ethics committee (REC)

Contact for Further Information

Sue Randall,

Coventry University, Priory Street, Coventry, CV1 5FB,

Tel [REDACTED] Mob [REDACTED] or email [REDACTED]

Thank you for considering your involvement in this study

[The second copy of this information sheet should be attached to your copy of the signed consent form]

Personal details have been removed from the electronic version of this thesis.



Carers' Information Sheet (new participants)

An Exploration of the Effects of Policy on the Community Matron Role

Part 1

You are being invited to take part in a research study, which will provide data for doctoral thesis. Before you decide whether or not to participate, 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 other members of your family, if you wish. Part 1 tells you the purpose of the study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study and gives details of who to contact for further details.

Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

At a time when a growing number of people have long-term conditions, it is important that consideration is given to how people with long-term conditions can best be cared for, in order for their lives and those of their carers to be as good as possible. The purpose of this study is to explore the essence of nursing through the role of community matron. It also wants to consider if hospital admissions may have been prevented.

In the study we want to:

- Examine the benefits to people living with long-term conditions of having access to services including Community Matrons
- Consider the benefits to health care organisations (community & acute) of the Community Matron role, in particular case management.
- Consider implications for practice, policy, education and research in the future

Why have I been chosen?

You have been chosen because your relative is receiving services from a community matron.

Do I have to take part?

No, the decision to take part is entirely yours. You may also refuse to answer any questions. You may of course withdraw from the study all together at any time. If you decline to take part in the study, or if you decide to withdraw you will not be asked for your reasons. It will not affect your care in any way.

What will I have to do, if I take part?

The study will involve you signing a consent form and being interviewed by a researcher, who is a nurse. This will take an hour.

Interviews will be audio-taped and your words may be used, but your name will not be used. Any interviews will take place at a mutually convenient time and place.

The purpose of the study is not to make judgements about the clinical practice of your relative's Community Matron, but rather to explore how you see the role of community matron, and to consider when admissions to hospital have been avoided, or discharges from hospital facilitated speedily.

What are the possible benefits of taking part?

By taking part you have an opportunity to influence the outcome of the study and ensure that a clear picture of what it is like to have a Community Matron. It may influence future education, professional practice and care of other people with long-term conditions.

What are the possible risks of taking part?

You might feel worried that your answers will affect the care your relative receives. This will not happen.

You may feel unwell during the course of the interview or the person you care for may feel unwell. The interview can be stopped without affecting any care you receive.

The researcher (Sue Randall) will try to answer any concerns you have but you can also get further advice from the Patient Advice and Liaison Services (PALS). If you live in Warwickshire, their telephone number is: 0845 423 8903 or by e-mail: pals@warkpct.nhs.uk Or if you live in Coventry their number is 024 7624 6002 or by e mail: PALS@coventrypct.nhs.uk

What happens when the research study stops?

All tapes of individual discussions will be destroyed. All information on you will also be destroyed. We will keep the transcripts of what has been said, but use a descriptor instead of people's real names. These transcripts will be kept at

Coventry University until the final report is accepted. If I plan to change this I will seek your consent.

Where can I get support and make complaints?

If taking part in this study has raised issue that you would like to discuss further you could contact the Patient Advice and Liaison Services (PALS). Their telephone number is: Warwickshire 0845 423 8903 ; or by e-mail: pals@warkpct.nhs.uk OR Coventry 024 7624 6002 or by e mail: PALS@coventrypct.nhs.uk

Or contact Sue Randall on [REDACTED]

Coventry University has public liability and professional indemnity insurance to cover negligent harm. In addition, where appropriate, honorary contracts will ensure inclusion of non-University personnel working on the research to be included. University staff will have honorary contracts with the NHS institution to include them within the NHS liability insurance.

Will my taking part in this study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2

All information, which is collected during the course of the study, will be kept strictly confidential unless to do so would breach the Nursing and Midwifery Code of Conduct (NMC 2008). Any information stored about you will have your name removed so that you cannot be recognised. All personal information will be stored in a locked filing cabinet in a locked room at Coventry University.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time without penalty. Any data already collected will still be used to inform the study, but will be anonymised.

What if there is a problem?

Any complaint about the way you have been dealt with during the study will be addressed. If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions, and to resolve the matter. Failing this, you may wish to contact the Coventry University Ethics

Committee chair, Professor Ian Marshall, in writing at AB122, Coventry University, Priory Street, Coventry CV1 5FB, or by telephone on [REDACTED]

In the event of a complaint relating to the NHS Trust, you should follow the usual NHS Trust complaints procedure.

Will my taking part in this study be kept confidential?

Data will be collected through interview . It will be anonymised and stored in a locked cabinet in a key code protected room, or on a password protected computer. It will be retained until the final thesis is accepted, at which point any data will be securely destroyed.

What will happen to the results of the research study?

If applicable, results will be incorporated into existing training and if necessary new training will be produced to fill any gaps, subject to funding. It will also be shared with relevant agencies including local and regional special interest groups. Conference papers will be submitted to appropriate forums to inform practitioners at a national level. The researcher will submit papers for publishing the results in relevant professional journals, in order to ensure wide dissemination to the target audience. A sheet of key findings will be produced for participants of the study.

Who is organising and funding the research?

This study is in fulfilment of a PhD in Nursing, Midwifery & Healthcare and is being undertaken at Coventry University. It is building on previous research which was funded by Heart of Birmingham teaching Primary Care Trust. This part of the study has no funding.

Who has reviewed the study?

This study will be peer reviewed at Coventry University and ethically approved by an appropriate research ethics committee (REC)

Contact for Further Information

Sue Randall,

Coventry University, Priory Street, Coventry, CV1 5FB,

Tel [REDACTED] Mob [REDACTED] or email [REDACTED]

Thank you for considering your involvement in this study

[The second copy of this information sheet should be attached to your copy of the signed consent form]

Community Matrons' information sheet (previous participants)

An Exploration of the Effects of Policy on the Community Matron Role

Part 1

In 2009, you were invited to take part in a research study titled Effectiveness of Community Matrons in Case Management and Prevention of Hospital Admissions. After reading an information sheet like this dated 20/3/2009 version 1 you signed a consent form agreeing to take part, dated 20/3/2009 version 1.

This information sheet explains that the data you provided in the form of focus group, individual interview and audio diary is requested for re-analysis in answer to a new study which builds on the one you took part in previously. The data previously provided will be used in a doctoral thesis which seeks to explore the essence of nursing through the role of the community matron.

Before you decide whether to consent to this additional use of the data you have already provided, 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 other members of the team, if you wish. Part 1 tells you the purpose of the study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study and gives details of who to contact for further details.

Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

At a time when effective management of individuals with long-term conditions is high on the health agenda, the purpose of this study is to explore the essence of nursing through the role of community matron.

In the study I want to:

- Explore your experiences of working as case managers and how you utilise the elements which make up case management.
- Examine the benefits to people living with long-term conditions of having access to services including Community Matrons

- Consider the benefits to health care organisations (community & acute) of the Community Matron role.
- Consider implications for practice, policy, education and research.

Why have I been chosen?

You have been chosen because you previously provided data as a Community Matron who case manages individuals with long-term conditions.

Do I have to take part?

No, the decision to allow the further use of data provided previously is entirely yours. You may refuse. You may of course withdraw from the study all together at any time. If you decline to take part in the study, or if you decide to withdraw you will not be asked for your reasons, no other colleague or manager will be informed of your actions.

What will I have to do, if I take part?

I will ask you to sign a new consent form which confirms that you have read this sheet and agree to the further analysis of information already provided.

What are the possible benefits of taking part?

By taking part you have an opportunity to influence the outcome of the study and ensure that a clear picture of what community matrons provide, and its influence on service users and professionals, is translated to a wide audience. It may influence future education, professional practice and care of individuals with long-term conditions.

What are the possible risks of taking part?

As the principal investigator (Sue Randall) is a registered nurse and Health Visitor, she has a duty to report any issues that might breach the Nursing and Midwifery Code of Conduct (NMC 2008). No report will be submitted without informing you. As the data has been analysed previously the risk of this is negligible.

If you feel the need to discuss any issues further, you can contact the Royal College of Nursing counselling service at www.rcn.org.uk/support/services or UNISON at www.unison.org.uk , or Occupational Health on 0121 424 7952, for support.

What happens when the research study stops?

All tapes of group & individual discussions will be destroyed. All information on you will also be destroyed. I will keep the transcripts of what has been said, but use a descriptor instead of people's real names. These transcripts will be kept at

Coventry University until the final report is accepted. If I plan to change this I will seek your consent.

Where can I get support and make complaints?

If taking part in this study has raised issue that you would like to discuss further you could contact the Royal College of Nursing counselling service at www.rcn.org.uk or UNISON at www.unison.org.uk or Occupational Health on 0121 424 7952, or contact Sue Randall on 024 7679 5879.

Coventry University has public liability and professional indemnity insurance to cover negligent harm. In addition, where appropriate, honorary contracts will ensure inclusion of non-University personnel working on the research to be included. University staff will have honorary contracts with the NHS institution to include them within the NHS liability insurance.

Will my taking part in this study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2

All information, which is collected during the course of the study, will be kept strictly confidential unless to do so would breach the Nursing and Midwifery Code of Conduct (NMC 2008). Any information stored about you will have your name removed so that you cannot be recognised. All personal information will be stored in a locked filing cabinet in a locked room at Coventry University.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time without penalty. Any data already collected will still be used to inform the study, but will be anonymised.

What if there is a problem?

Any complaint about the way you have been dealt with during the study will be addressed. If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions, and to resolve the matter. Failing this, you may wish to contact the Coventry University Ethics Committee chair, Professor Ian Marshall, in writing at AB122, Coventry University, Priory Street, Coventry CV1 5FB, or by telephone on [REDACTED]

In the event of a complaint relating to the NHS Trust, you should follow the usual NHS Trust complaints procedure.

Will my taking part in this study be kept confidential?

Data collected through focus group, interview and audio diary has already been anonymised. It is stored in a locked cabinet in a key code protected room, or on a password protected computer. It will be retained until the final thesis is accepted, at which point any data will be securely destroyed.

What will happen to the results of the research study?

If applicable, results will be incorporated into existing training and if necessary new training will be produced to fill any gaps, subject to funding. It will also be shared with relevant agencies including local and regional special interest groups. Conference papers will be submitted to appropriate forums to inform practitioners at a national level. The researcher will submit papers for publishing the results in relevant professional journals, in order to ensure wide dissemination to the target audience.

Who is organising and funding the research?

This study is in fulfilment of a PhD in Nursing, Midwifery & Healthcare and is being undertaken at Coventry University. It is building on previous research which was funded by Heart of Birmingham teaching Primary Care Trust. This part of the study has no funding.

Who has reviewed the study?

This study will be peer reviewed at Coventry University and ethically approved by an appropriate research ethics committee (REC)

Contact for Further Information

Sue Randall

RC 345, Richard Crossman Building, Coventry University, Priory Street, Coventry,
CV1 5FB

Tel [REDACTED] Mob [REDACTED] or email [REDACTED]

Thank you for considering allowing previously collected data to be included in this study

[The second copy of this information sheet should be attached to your copy of the signed consent form]

Community Matrons' information sheet (new)

An exploration of the effects of policy on the community matron role

Part 1

You are being invited to take part in a research study, which will provide data for doctoral thesis. Before you decide whether or not to participate, 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 other members of the team, if you wish. Part 1 tells you the purpose of the study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study and gives details of who to contact for further details.

Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

At a time when effective management of individuals with long-term conditions is high on the health agenda, the purpose of this study is to explore the essence of nursing through the role of community matron.

In the study I want to:

- Explore your experiences of working as case managers and how you utilise the elements which make up case management.
- Examine the benefits to people living with long-term conditions of having access to services including Community Matrons
- Consider the benefits to health care organisations (community & acute) of the Community Matron role.
- Consider implications for practice, policy, education and research.

Why have I been chosen?

You have been chosen because you are a Community Matron who case manages individuals with long-term conditions.

Do I have to take part?

No, the decision to take part is entirely yours. You may also refuse to answer any questions. You may of course withdraw from the study all together at any time. If you decline to take part in the study, or if you decide to withdraw you will not be asked for your reasons, no other colleague or manager will be informed of your actions.

What will I have to do, if I take part?

The study will involve you signing a consent form, participating in a maximum of 2 focus group with your community matron colleagues. Each will last an hour.

You will be asked to keep an audio diary, over a period of 1-2 weeks.

The study will involve you being interviewed. The interview will be no longer than an hour in duration. It will be audio-taped and your words may be used, but your name will not be used. The interview will take place at a mutually convenient time and place.

The purpose of the study is not to make judgements about individual clinical practice, but rather to explore how community matrons practice nursing, what aspects of care are considered to be key, and to consider when admissions to hospital have been avoided. Undertaking all aspects (focus group, interview, audio diary) is negotiable with the principal investigator.

What are the possible benefits of taking part?

By taking part you have an opportunity to influence the outcome of the study and ensure that a clear picture of what community matrons provide, and its influence on service users and professionals, is translated to a wide audience. It may influence future education, professional practice and care of individuals with long-term conditions.

What are the possible risks of taking part?

As the principal investigator (Sue Randall) is a registered nurse and Health Visitor, she has a duty to report any issues that might breach the Nursing and Midwifery Code of Conduct (NMC 2008). No report will be submitted without informing you.

If you feel the need to discuss any issues further, you can contact the Royal College of Nursing counselling service at www.rcn.org.uk/support/services or UNISON at www.unison.org.uk , or Occupational Health on 0121 424 7952, for support.

What happens when the research study stops?

All tapes of group & individual discussions will be destroyed. All information on you will also be destroyed. We will keep the transcripts of what has been said, but use a descriptor instead of people's real names. These transcripts will be kept at Coventry University until the final report is accepted. If I plan to change this I will seek your consent.

Where can I get support and make complaints?

If taking part in this study has raised issue that you would like to discuss further you could contact the Royal College of Nursing counselling service at www.rcn.org.uk or UNISON at www.unison.org.uk or Occupational Health on 0121 424 7952, or contact Sue Randall on 024 7679 5879.

Coventry University has public liability and professional indemnity insurance to cover negligent harm. In addition, where appropriate, honorary contracts will ensure inclusion of non-University personnel working on the research to be included. University staff will have honorary contracts with the NHS institution to include them within the NHS liability insurance.

Will my taking part in this study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2

All information, which is collected during the course of the study, will be kept strictly confidential unless to do so would breach the Nursing and Midwifery Code of Conduct (NMC 2008). Any information stored about you will have your name removed so that you cannot be recognised. All personal information will be stored in a locked filing cabinet in a locked room at Coventry University

If the information in Part 1 has interested you and you are considering participation, please read the additional information in part 2 before making any decision.

Part 2**What will happen if I don't want to carry on with the study?**

You are free to withdraw from the study at any time without penalty. Any data already collected will still be used to inform the study, but will be anonymised.

What if there is a problem?

Any complaint about the way you have been dealt with during the study will be addressed. If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions, and to resolve

the matter. Failing this, you may wish to contact the Coventry University Ethics Committee chair, Professor Ian Marshall, in writing at AB122, Coventry University, Priory Street, Coventry CV1 5FB, or by telephone on 024 7688 5293.

In the event of a complaint relating to the NHS Trust, you should follow the usual NHS Trust complaints procedure.

Will my taking part in this study be kept confidential?

Data will be collected through focus group, interview and audio diary. It will be anonymised and stored in a locked cabinet in a key code protected room, or on a password protected computer. It will be retained until the final thesis is accepted, at which point any data will be securely destroyed.

What will happen to the results of the research study?

If applicable, results will be incorporated into existing training and if necessary new training will be produced to fill any gaps, subject to funding. It will also be shared with relevant agencies including local and regional special interest groups. Conference papers will be submitted to appropriate forums to inform practitioners at a national level. The researcher will submit papers for publishing the results in relevant professional journals, in order to ensure wide dissemination to the target audience.

Who is organising and funding the research?

This study is in fulfilment of a PhD in Nursing, Midwifery & Healthcare and is being undertaken at Coventry University. It is building on previous research which was funded by Heart of Birmingham teaching Primary Care Trust. This part of the study has no funding.

Who has reviewed the study?

This study will be peer reviewed at Coventry University and ethically approved by an appropriate research ethics committee (REC)

Contact for Further Information

Sue Randall

RC 345, Richard Crossman Building, Coventry University, Priory Street, Coventry,
CV1 5FB

Tel [REDACTED] Mob [REDACTED] or email [REDACTED]

Thank you for considering your involvement in this study

[The second copy of this information sheet should be attached to your copy of the signed consent form]

Health Care Employees' Information Sheet

An Exploration of the Effects of Policy on the Community Matron Role

Part 1

You are being invited to take part in a research study, which will provide data for doctoral thesis. Before you decide whether or not to participate, 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 other members of the team, if you wish. Part 1 tells you the purpose of the study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study and gives details of who to contact for further details.

Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

At a time when effective management of individuals with long-term conditions is high on the health agenda, the purpose of this study is to exploring the essence of nursing through the role of community matron.

In the study I want to:

- Examine the perceived benefits to people living with long-term conditions of having access to services including Community Matrons
- Consider the benefits to health care organisations (community & acute) of the Community Matron role, in particular case management.
- Consider how such roles embed and factors which influence service redesign
- Consider implications for practice, policy, education and research.

Why have I been chosen?

You have been chosen because you are in a group of key informants, as determined by the researcher in discussion with her supervisory team at Coventry University who may have previous experience or future role in commissioning or service delivery or re-design around the role of community matron and managing individuals who have long-term conditions.

Do I have to take part?

No, the decision to take part is entirely yours. You may also refuse to answer any questions. You may of course withdraw from the study all together at any time. If you decline to take part in the study, or if you decide to withdraw you will not be asked for your reasons, no other colleague or manager will be informed of your actions.

What will I have to do, if I take part?

If you are a **General Practitioner**, the study will involve you undertaking a telephone or face to face interview, lasting no more than an hour.

If you are a **commissioner**, the study will involve you participating in a telephone or face to face interview with a researcher, lasting no more than an hour

If you are **provider** based, the study will involve you participating in a telephone or face to face interview with a researcher, lasting no more than an hour

For all groups, interviews will be audio-taped and your words may be used, but your name will not be used. Any interviews will take place at a mutually convenient time and place.

The purpose of the study is not to make judgements about individuals, but rather to explore how but rather to explore how the role of community matron has been embedded, what aspects of care are considered to be key, factors which may have influenced service re design and to consider when admissions to hospital have been avoided. or discharges from hospital facilitated speedily.

What are the possible benefits of taking part?

By taking part you have an opportunity to influence the outcome of the study and ensure that a clear picture of processes which impact on new roles embedding. It may influence future education, professional practice and care of individuals with long-term conditions.

What are the possible risks of taking part?

As the principal investigator (Sue Randall) is a registered nurse and Health Visitor, she has a duty to report any issues that might breach the Nursing and Midwifery Code of Conduct (NMC 2008). No report will be submitted without informing you. If you feel the need to discuss any issues further, and you are a nurse, you can contact the Royal College of Nursing counselling service at www.rcn.org.uk/support/services or UNISON at www.unison.org.uk , or Occupational Health for support. If you are a GP, contact Doctors' health and wellbeing at the British Medical Association:

www.bma.org.uk/doctors_health/index.jsp or telephone the BMA counselling service on 08459 200 169.

What happens when the research study stops?

All tapes of group & individual discussions will be destroyed. All information on you will also be destroyed. We will keep the transcripts of what has been said, but use a descriptor instead of people's real names. These transcripts will be kept at Coventry University until the final report is accepted. If we plan to change this we will seek your consent.

Where can I get support and make complaints?

If taking part in this study has raised issue that you would like to discuss further you could contact the organisations listed above, or contact Sue Randall on [REDACTED]
[REDACTED]

Coventry University has public liability and professional indemnity insurance to cover negligent harm. In addition, where appropriate, honorary contracts will ensure inclusion of non-University personnel working on the research to be included. University staff will have honorary contracts with the NHS institution to include them within the NHS liability insurance.

Will my taking part in this study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2

All information, which is collected during the course of the study, will be kept strictly confidential unless to do so would breach the Nursing and Midwifery Code of Conduct (NMC 2008). Any information stored about you will have your name removed so that you cannot be recognised. All personal information will be stored in a locked filing cabinet in a locked room at Coventry University.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time without penalty. Any data already collected will still be used to inform the study, but will be anonymised.

What if there is a problem?

Any complaint about the way you have been dealt with during the study will be addressed. If you have a concern about any aspect of this study, you should speak

to the researchers who will do their best to answer your questions, and to resolve the matter. Failing this, you may wish to contact the Coventry University Ethics Committee chair, Professor Ian Marshall, in writing at AB122, Coventry University, Priory Street, Coventry CV1 5FB, or by telephone on [REDACTED]

In the event of a complaint relating to the NHS Trust, you should follow the usual NHS Trust complaints procedure.

Will my taking part in this study be kept confidential?

Data will be collected through focus group and interview . It will be anonymised and stored in a locked cabinet in a key code protected room, or on a password protected computer. It will be retained until the final thesis is accepted, at which point any data will be securely destroyed.

What will happen to the results of the research study?

If applicable, results will be incorporated into existing training and if necessary new training will be produced to fill any gaps, subject to funding. It will also be shared with relevant agencies including local and regional special interest groups. Conference papers will be submitted to appropriate forums to inform practitioners at a national level. The researcher will submit papers for publishing the results in relevant professional journals, in order to ensure wide dissemination to the target audience. A sheet of key findings will be produced for participants of the study.

Who is organising and funding the research?

This study is in fulfilment of a PhD in Nursing, Midwifery & Healthcare and is being undertaken at Coventry University. It is building on previous research which was funded by Heart of Birmingham teaching Primary Care Trust. This part of the study has no funding.

Who has reviewed the study?

This study will be peer reviewed at Coventry University and ethically approved by an appropriate research ethics committee (REC)

Contact for Further Information

Sue Randall

Coventry University, Priory Street, Coventry, CV1 5FB

Tel [REDACTED] Mob [REDACTED] or email [REDACTED]

Thank you for considering your involvement in this study

[The second copy of this information sheet should be attached to your copy of the signed consent form]

CONSENT FORM A: Patient (previous study)

Title of Project: An exploration of the effects of policy on the community matron role

Name of Researcher: Sue Randall

Please initial boxes

- 1 I confirm that I have read and understand the information sheet dated 21/3/2011 (Version 1) for the above study and have had the opportunity to consider the information, to ask questions and have these answered satisfactorily ☐
- 2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without penalty. ☐
- 3 I agree that information collected from previous study: Effectiveness of Community Matrons in Case Management and Prevention of Hospital Admissions through interview can be re-analysed for the above study ☐
- 4 I agree that my health care records may be re-analysed by the researcher ☐
- 5 I understand that all information, including my words may be used in journal publications or conference presentations, but I will not be identified. ☐

_____	_____	_____
Name	Date	Signature
_____	_____	_____
Researcher	Signature	Date

Copies 1 for participant; 1 for researcher.

CONSENT FORM G: Carers (previous)

Title of Project: **An exploration of the effects of policy on the community matron role**

Name of Researcher: Sue Randall

Please initial boxes

- 1 I confirm that I have read and understand the information sheet dated 21/3/2011 (Version 1) for the above study and have had the opportunity to consider the information, to ask questions and have these answered satisfactorily ☐
- 2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without penalty. ☐
- 3 I agree that information collected from previous study: Effectiveness of Community Matrons in Case Management and Prevention of Hospital Admissions through interview can be re-analysed for the above study, used in journal publications and conference presentations, but that I will not be identified. ☐

_____ Name	_____ Date	_____ Signature
_____ Researcher	_____ Signature	_____ Date

Copies 1 for participant; 1 for researcher.

CONSENT FORM : Patient (new)

Title of Project: **An exploration of the effects of policy on the community
matron role**

Name of Researcher: Sue Randall

Please initial boxes

- 1 I confirm that I have read and understand the information sheet dated 6/9/2011 (Version 3) for the above study and have had the opportunity to consider the information, to ask questions and have these answered satisfactorily ☐
- 2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without penalty. ☐
- 3 I understand that I will be interviewed, and that my voice may be recorded, and that my words may be used in the study, future journal articles and conference presentations, but I will not be identified. ☐
- 4 I agree that my health care records may be reviewed by the research team. ☐
- 5 I agree to take part in the above study ☐

_____	_____	_____
Name	Date	Signature
_____	_____	_____
Researcher	Signature	Date

Copies 1 for participant; 1 for researcher.

CONSENT FORM : Carers (new)

Title of Project: **An exploration of the effects of policy on the community matron role**

Name of Researcher: Sue Randall

Please initial boxes

- 1 I confirm that I have read and understand the information sheet dated 6/9/11 (Version 3) for the above study and have had the opportunity to consider the information, to ask questions and have these answered satisfactorily ☐
- 2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without penalty. ☐
- 3 I understand that I may be interviewed, and that my voice may be recorded, and that my words may be used in the study, future journal publications and conference presentations, but I will not be identified . ☐
- 4 I agree to take part in the above study ☐

_____ Name	_____ Date	_____ Signature
_____ Researcher	_____ Signature	_____ Date

Copies 1 for participant; 1 for researcher.

CONSENT FORM C: Community Matron (previous)

Title of Project: **An exploration of the effects of policy on the community matron role**

Name of Researcher: Sue Randall

Please initial boxes

- 1 I confirm that I have read and understand the information sheet dated 20/3/2011 (Version 1) for the above study and have had the opportunity to consider the information, to ask questions and have these answered satisfactorily ☐
- 2 I agree that information collected from previous study: Effectiveness of Community Matrons in Case Management and Prevention of Hospital Admissions through focus group, interview and audio diary can be re-analysed for the above study and may be reported in journal articles, and conference presentations, but I will not be identified. ☐

_____	_____	_____
Name	Date	Signature
_____	_____	_____
Researcher	Signature	Date

Copies 1 for participant; 1 for researcher.

CONSENT FORM D: Community Matron (new)

Title of Project: **An exploration of the effects of policy on the community matron role**

Name of Researcher: Sue Randall

Please initial boxes

- | | | |
|---|--|--------------------------|
| 1 | I confirm that I have read and understand the information sheet dated 20/3/2011 (Version 2) for the above study and have had the opportunity to consider the information, to ask questions and have these answered satisfactorily | <input type="checkbox"/> |
| 2 | I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without penalty. | <input type="checkbox"/> |
| 3 | I understand that I will participate in a focus group with other Community Matrons, keep an audio diary and be interviewed independently, and that my voice may be recorded, and that my words may be used in the study, in future journal articles and conference presentations, but that I will not be identified. | <input type="checkbox"/> |
| 4 | I agree to take part in the above study | <input type="checkbox"/> |

Name	Date	Signature
Researcher	Signature	Date

Copies 1 for participant; 1 for researcher.

CONSENT FORM E: Healthcare Employees ^(new)

Title of Project: **An exploration of the effects of policy on the community matron role**

Name of Researcher: Sue Randall

Please initial boxes

- | | | |
|---|---|--------------------------|
| 1 | I confirm that I have read and understand the information sheet dated 21/3/2011 (Version 1) for the above study and have had the opportunity to consider the information, to ask questions and have these answered satisfactorily | <input type="checkbox"/> |
| 2 | I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without penalty. | <input type="checkbox"/> |
| 3 | I understand that I will be interviewed (by telephone or face to face), and that my voice may be recorded, and that my words may be used in the study, in future journal publications and conference presentations, but I will not be identified. | <input type="checkbox"/> |
| 4 | I agree to take part in the above study | <input type="checkbox"/> |

_____ Name	_____ Date	_____ Signature
_____ Researcher	_____ Signature	_____ Date

Copies 1 for participant; 1 for researcher.

Appendix 8: Participant Questions



Face to face patient questions

How do you feel about the care and support you get from your CM?

How do you feel about the information given to you by your community matron about your condition and the treatment you receive?

What do you understand by your medical condition?

How well do you feel that you understand the medication/s that you take and how they affect you?

How confident do you feel about getting help when you start to feel unwell?

How do you feel that your care has been coordinated with other services, by the CM

How have changes to the CM service affected you?



Face to face family carer questions

How do you feel about the care and support that your relative gets from the CM?

How do you feel about the information given to you and your relative by the CM about the condition your relative has and the treatment that your relative receives?

What do you and your relative understand about their medical condition?

How well do you feel that you and your relative understand the medication/s that they take and how these may affect them?

How confident do you feel about getting help when your relative starts to feel unwell?

How do you feel about the way that your relative's care has been coordinated by the community matron, with other services?

Are you aware of changes to the service received by your relatives?



Questions for individual community matrons

What experience and qualifications have you brought to this role and how have your educational needs been met whilst in post?

How does the service model for community matrons work in this area

What, if any, changes have there been to the model?

What rationale was given for the changes

How do you think you have implemented the domains of case management and what skills have allowed you to meet them? (skills needed to improve?)

How effective are you as a community matron in organising complex care co ordination?

- Record keeping, particularly in relation to:
 - GPs
 - Other agencies
 - Prescribing records

How proactive in managing complex LTC do you consider yourself as a CM to be?

In what ways are you as a CM able to manage cognitive impairment & mental wellbeing?

What knowledge, examples do you have as a CM supporting self care, self-management & enabling independence amongst the clients you see?

How effective are your leadership skills?

How effective are you, as a CM, at identifying high risk individuals (and promoting health and in preventing ill health)?

How do you perceive your role in end of life care?

How effective are you as a CM at interagency and partnership working, such as with yourself and your team?



Question areas for commissioners/provider arm managers

Why did community matrons come into post?

How was the role set up in this area?

How does this compare with other areas you may have knowledge of?

What rationale underpinned the set up of the service?

How have alterations in service design come about?

What aspects of the role of CM are considered beneficial?

Why?

What disadvantages are there to the service in this area?

Why?

How do other services work with CM service? GPs, Intermediate care, acute providers, DNs?

How are CMs evaluated in this area?



Question areas for GPs

Can I ask how long you have been a GP?

And what's your role within the new commissioning structure?

Describe your view of the community matron service where you work

Which aspects of the service work well?

Can you suggest ways to improve the service?

If you were to be contributing to commissioning, what aspects of the community matron service would you see as valuable in the management of individuals with LTCs?

How would you say it has been received in GP land generally?

How do policy directives influence your opinion?

Appendix 9: Conceptual Framework: themes, elements and definitions

Overarching theme linked to adapted Liaschenko and Fisher	Theme	Elements and definitions
Policy (macro) including influences from national and organisational policies	Implementation of community matron role and effects	<p>Role: Set up, changes associated with misunderstandings, funding, different referral criteria, organisational and systems issues, embedding</p> <p>Advanced nursing skills: Mainly referred to in terms of technical skills so NMP, physical assessment & differential diagnosis</p> <p>Skills and expertise, value of service, effects on other services</p> <p>Hospital admissions: Proactive prevention; appropriate; unnecessary</p> <p>Showing impact, influence of policy, value: keeping people out of hospital</p> <p>Case Finding: Use of tools; difficulties; other means of case finding</p> <p>Integration & whole systems working: Policy influence; vision</p> <p>Joint visits: Use of joint visits with other HCPs as a means of support/learning</p> <p>Relationships: Particularly between health care professionals</p> <p>Capacity: Ability to take on new referrals; Limitations of service set up; changes to models</p> <p>Grade of staff: Different grades for same role & associated differences in work. Introduction of skill mix</p> <p>Perspectives of HCPs, pts, carers and CMs</p> <p>Commissioning: Changes to commissioning as a result of policy</p> <p>Views of CCG members and former commissioners</p>

Overarching theme linked to adapted Liaschenko and Fisher	Theme	Elements and definitions
Patient (meso)	Delivering health care	<p>Health promotion: medication of lifestyle, exercise, stopping smoking, pt & carer perspective; HCP perspective</p> <p>Communication: perceptions and experiences of communication with patients and carers and across professional boundaries as it affects them as a person</p> <p>Medication: understanding of medication and actions to achieve improved concordance. Pt & carer perspective; HCP perspective</p> <p>Leadership/management: qualities shown in relation to leadership. Changing expectations in relationship to leadership and management of patient care</p> <p>Telehealth: Introduction of this means of monitoring pt vital signs by pt & then relayed to HCPs</p> <p>End of life: Discussed in relation to role of CM not discussed with patients</p>

Overarching theme linked to adapted Liaschenko and Fisher	Theme	Elements and definitions
Person (micro)	Psychosocial	<p>Support: support groups, pt and carer wellbeing, relationship, trust, reassurance, time to ask questions. As perceived by pts and carers</p> <p>Advocacy: a noted part of the role where community matrons worked in partnership with and on behalf of patients to resolve issues which were important to patients and carers</p> <p>Mental wellbeing: not just mental wellbeing but rather worries and anxieties in relation to living with a LTC. HCPs anxieties in relation to services available to support this area</p> <p>Non adjustment to a LTC by patients. Patient view;</p>

		community matron view
Overarching theme linked to adapted Liaschenko and Fisher	Theme	Elements and definitions
Person (micro)	Patient Journey	<p>Referrals: across agencies,</p> <p>Care coordination: Organisation of care across different services: health, social care, 3rd sector</p> <p>Out of hours: Service fragmentation. Historical factors of 9-5 working. Ineffective communication</p> <p>Discharge: This is explored in relation to discharge from hospital and the positives and negatives associated with this process on the community matrons. Secondly it explores discharge from caseloads and how this is viewed by patients, carers and community matrons</p> <p>Self-management / independence: broad ranging and including patients' understanding of their health & disease. What patients wanted to know. How their self-efficacy & ability to recognise exacerbations & seek help were developed. Use of management plans by HCPs. Barriers to success. How pts showed growing skill</p> <p>Perspectives of pts, carers and CMs</p>
	Invisibility	<p>Value of community matron work as seen by patients and carers</p> <p>Emotional impact on community matrons: managing individuals who are very sick, limited resources, varying level of help and support from other HCPs, changes in service delivery model, clinical supervision</p> <p>Time: in relation to documentation, and care coordination. Unseen time</p>

Appendix 10: Worked example of analysis

Patient Participant: Patrick (P)(Informal carer: April [A])		
Concept	Verbatim Transcription	Ref
Self-management	<p><i>'A: we keep them in stock because we are never sure when his chest is suddenly going to get worse; it could be in the middle of the night.</i></p> <p><i>P: and then I start taking them, but then again CM says you can't be taking them all the time and I said what do you mean and she said they could be harmful if you take them everyday...but just when you feel ill.'</i></p>	81-85
	<i>P: 'I write when I take them in it. say like I started on a particular day and finished on a particular day and when I start again I write it next to my diabetes blood sugar.'</i>	86-87
	<p>Researcher: how do you know you are getting sicker?</p> <p><i>P: 'CM told me it's your blood, your sugar. I use that bottle for it. She says you can tell by your sputum and by the colour, so that's what I go by.'</i></p>	88-90
	<i>P: 'so you can see when I started and finished them.'</i>	93

Section of chart for element of self-management

Patrick's comments from transcript charted alongside comments from other participants	
Patient	Self-management
Rory	<i>'The idea is that me weight is a good guide to me heart problems. Any increase in weight is a sign that my ticker is going dicky' 31-32</i>
Patrick	<i>'She says (CM) that you can tell by the sputum and by the colour so that's what I go by.'89-90</i>
Harry	<i>'When I just had them (medicines) in boxes, I used to forget to have em and then I wondered why i get pains in my chest...so she sorted that out for me (blister packs) and I know to take em every morning, so they're on a table by my bed and I take em as soon as I wake up.' 68-71</i>
Maud	<i>'I know when I need to take them (rescue meds)'73</i>

Appendix 11: Tests of normality

Tests of Normality in Intervention Group (1): hospital bed days versus risk score (0=medium; 1=high)

Tests of Normality^a

RISK SCORE	Kolmogorov-Smirnov ^b			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
0	.225	64	<0.001	.744	64	<0.001
HOSP DAYS 1	.189	42	.001	.805	42	<0.001

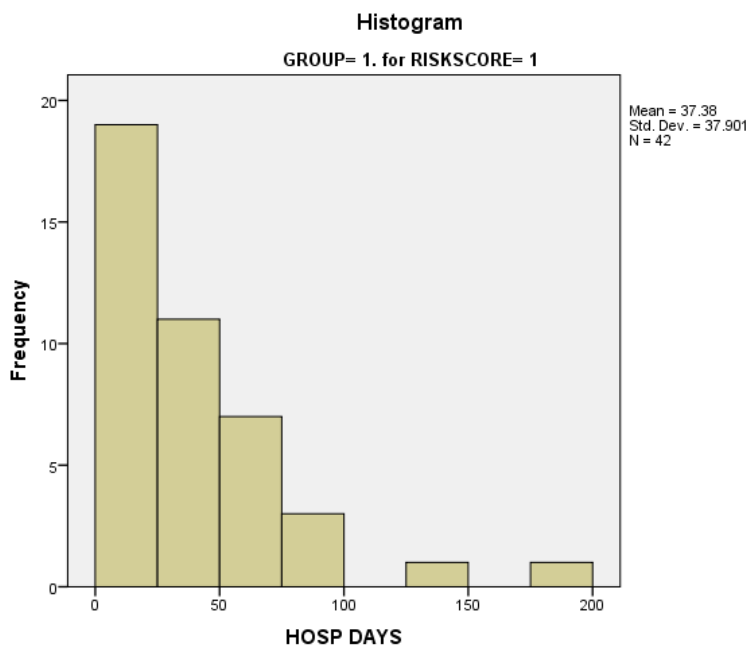
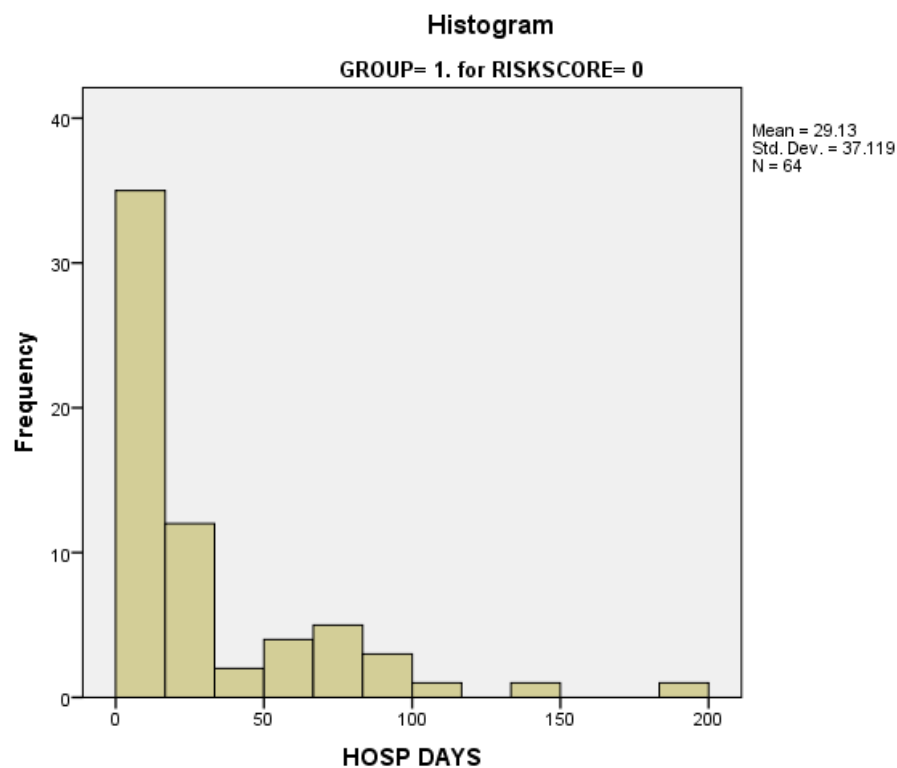
Tests of Normality in Comparison group (2): hospital bed days versus risk score (0=medium; 1=high)

Tests of Normality^a

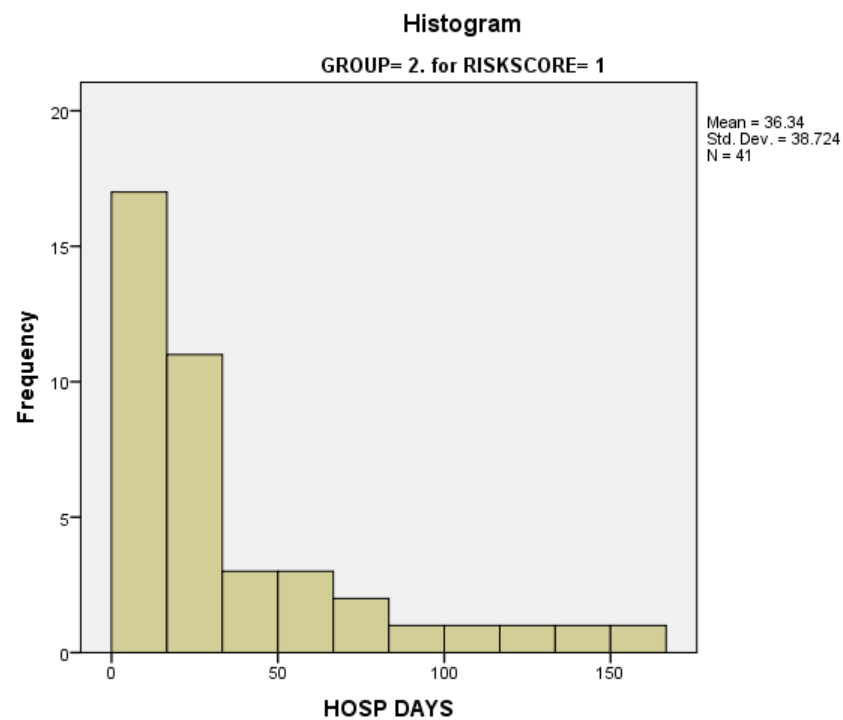
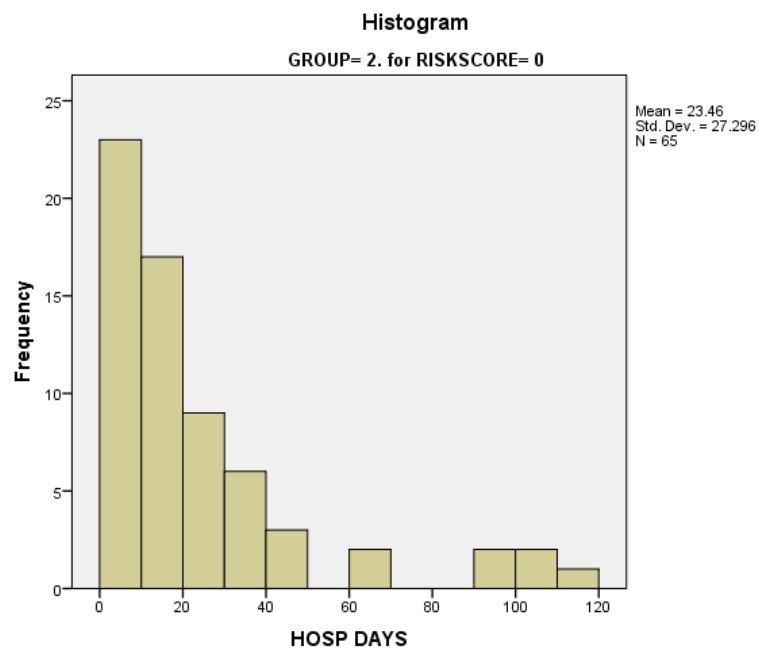
RISK SCORE	Kolmogorov-Smirnov ^b			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
0	.198	65	<0.001	.733	65	<0.001
HOSP DAYS 1	.221	41	<0.001	.782	41	<0.001

Appendix 12: Histograms

Histogram of Intervention group (1): hospital bed days versus medium risk score (0) and high risk score (1)



Histogram of comparison group (2): hospital bed days versus medium risk score (0) and high risk score (1)

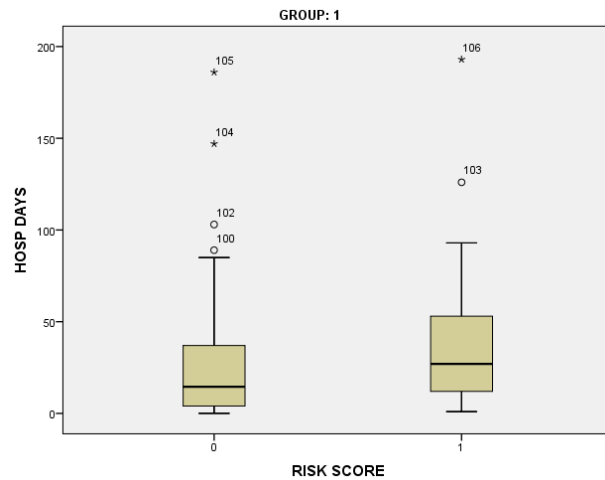


Appendix 13: Additional SPSS data: descriptive statistics and box plots

Descriptive statistics for intervention group (1): hospital days statistics by risk category

Descriptives				
Risk category	Hospital Days		Statistic	Std. Error
Medium Risk	Mean		29.13	4.640
	95% Confidence Interval for Mean	Lower Bound	19.85	
		Upper Bound	38.40	
	5% Trimmed Mean		24.48	
	Median		14.50	
	Variance		1377.83	
	Std. Deviation		37.119	
	Minimum		0	
	Maximum		186	
	Range		186	
	Interquartile Range		35	
	Skewness		2.09	.299
	Kurtosis		5.10	.590
High Risk	Mean		37.38	5.848
	95% Confidence Interval for Mean	Lower Bound	25.57	
		Upper Bound	49.19	
	5% Trimmed Mean		32.79	
	Median		27.00	
	Variance		1436.49	
	Std. Deviation		37.90	
	Minimum		1	
	Maximum		193	
	Range		192	
	Interquartile Range		42	
	Skewness		2.11	.365
	Kurtosis		6.13	.717

Box Plot for intervention group (1): hospital days and risk scores (0=medium; 1=high)

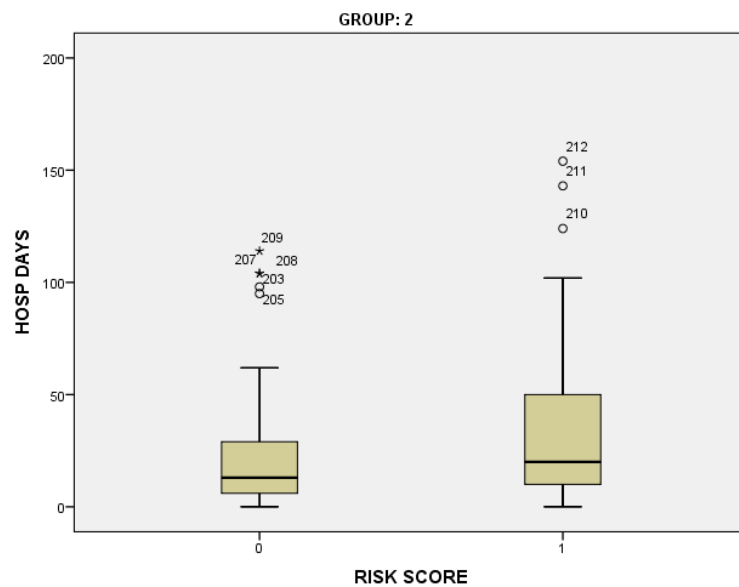


Descriptive statistics for comparison group (2): hospital days statistics by risk category

Descriptives				
Risk Category	Hospital Days		Statistic	Std. Error
Medium Risk	Mean		23.46	3.386
	95% Confidence Interval for Mean	Lower Bound	16.70	
		Upper Bound	30.23	
	5% Trimmed Mean		20.14	
	Median		13.00	
	Variance		745.07	
	Std. Deviation		27.30	
	Minimum		0	
	Maximum		114	
	Range		114	
	Interquartile Range		24	
	Skewness		2.01	.297
	Kurtosis		3.58	.586
High Risk	Mean		36.34	6.048
	95% Confidence Interval for Mean	Lower Bound	24.12	
		Upper Bound	48.56	
	5% Trimmed Mean		32.13	
	Median		20.00	
	Variance		1499.53	
	Std. Deviation		38.724	
	Minimum		0	
	Maximum		154	
	Range		154	

	Interquartile Range	41	
	Skewness	1.70	.369
	Kurtosis	2.29	.724

Box Plot for intervention group (1): hospital days and risk scores (0=medium; 1=high)



Appendix 14: Themes

'Agreeing ways of working without understanding': implementation of community matron role and effects

Role implementation

Skills & background

Case finding

Capacity and service delivery models

Grade of staff

Integrated care

HCP relationships

Joint visits

Changes to commissioning

'A little bit of extra effort': delivery of healthcare by community matrons

Health promotion

Communication

Medication

Leadership & management

Telehealth

End of life

'Climbing Mount Everest': psychosocial aspects of living with a LTC

Support

Mental well being

Non adjustment

Advocacy

'A jigsaw of care': patient Journey

Referral

Care coordination

Hospital admissions

Out of hours

Discharge

Self-management & independence

'I can't walk away': the invisible role of the community matron

Value of com matron work

Emotional impact

Time

Appendix 15: Themes linked to adapted Liaschenko and Fisher (1999)

Policy (Macro)	Patient (Meso)	Person (Micro)		
<p><i>'Agreeing ways of working without understanding': implementation of community matron role and effects</i></p> <p>Role implementation</p> <p>Skills & background</p> <p>Case finding</p> <p>Capacity and service delivery models</p> <p>Grade of staff</p> <p>Integrated care</p> <p>HCP relationships</p> <p>Joint visits (bridge element)</p> <p>Changes to commissioning</p>	<p><i>'A little bit of extra effort': delivery of healthcare by community matrons</i></p> <p>Health promotion</p> <p>Communication</p> <p>Medication</p> <p>Leadership & management</p> <p>Telehealth</p> <p>End of life</p>	<p><i>'Climbing Mount Everest': psychosocial aspects of living with a LTC</i></p> <p>Support</p> <p>Mental well being</p> <p>Advocacy</p> <p>Non adjustment</p>	<p><i>'A jigsaw of care': patient journey</i></p> <p>Out of hours</p> <p>Care coordination</p> <p>Referral</p> <p>Self-management & independence</p> <p>Hospital admissions</p> <p>Discharge</p>	<p><i>'I can't walk away': the invisible role of the community matron</i></p> <p>Value of community matron work</p> <p>Emotional impact</p> <p>Time</p>