Knowing long-term conditions:
Understanding the role and practice of the Community Matron

Dr Verina Waights
Professor Shirley Reveley
Dr Caroline Holland

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Contacts:  Dr Verina Waights v.waights@open.ac.uk
          Dr Caroline Holland c.a.holland@open.ac.uk
Table of Contents

Table of Contents ...............................................................................................................2
Executive Summary ...............................................................................................................3
Introduction ..........................................................................................................................4
  Levels of patient care ......................................................................................................4
  Competency Framework .................................................................................................5
  Background to the study .................................................................................................6
  Aims and Objectives .......................................................................................................7
Methodology .......................................................................................................................7
Findings ..............................................................................................................................8
  Differences and similarities between practice-based and city-wide service .................8
  Education for the role – formal learning ........................................................................9
  Education for the role - informal learning .....................................................................10
  Becoming experts .........................................................................................................12
Discussion ........................................................................................................................14
Conclusions .......................................................................................................................15
References .........................................................................................................................15
Impact ...............................................................................................................................17
Deliverables .......................................................................................................................17
Dissemination ...................................................................................................................17
Commentary .....................................................................................................................17
Executive Summary

In 2005, the Government introduced the role of Community Matrons across the country. Community Matrons identify patients with complex long-term conditions, particularly those at high risk, co-ordinate their care and promote effective self-care to enable people with long-term conditions to remain at home longer and have more choice about their health and social care. As the Community Matron role was new, individuals were appointed with the understanding that they did not initially possess all the skills and knowledge required to develop a Community Matron service in their area. To date, there has not yet been an in-depth study of the types of knowledge that underpin the role: how these types of knowledge are perceived by other professionals and service users/carers, and how the understandings, perceptions and expectations of significant stakeholders affect practice.

The aim of this project was to investigate the reality of the role of Community Matron and to examine the nature of the knowledge bases - tacit, experiential and formalised - from which practice is being developed. The project aimed to produce an in-depth case study that relates the research findings to key literature and other data on tacit and experiential knowledge and competencies.

Following ethical approval from the Open University Human Participants and Materials Ethics Committee and the NHS Oxford COREC, all potential participants, comprising eight Community Matrons employed across a city in Southern England, were invited by letter to join the study. Six of the eight agreed to participate in individual semi-structured interviews. The recorded interviews were transcribed verbatim and analysed using thematic analysis.

The study found two different models of care by Community Matrons have been developed in the city. In one model Community Matrons provide a service across the city that is linked to several GP practices, in the other model Community Matrons are linked to primarily to one GP practice, and have a less frequent role with another. Analysis of the data revealed previous training and experience had enabled Community Matrons to develop competent skills for ‘reflecting-in’ and ‘reflecting-on’ practice (Schön, 1987) and to use these skills to identify their own training needs and personal acquisition of formalised knowledge. They also felt experiential learning became increasing important as they honed their practice skills and embedded formal knowledge into their practice.

This study suggests Community Matrons perceive themselves as autonomous practitioners, who identify their own training needs and personal acquisition of knowledge, both formal and experiential. These Community Matrons believe that to be effective practitioners they need to draw on the knowledge of service users and carers about each individual’s particular conditions and need depth and breadth of knowledge about their locality to enable them to access appropriate services quickly. They feel past clinical experience, community experience, communication skills and life skills are all equally important in preparing individuals for the Community Matron role. However, an important aspect of their ongoing development is to share knowledge and participate in distributed learning, whereby all professionals involved in an individual’s care learn from and support each other to develop expert knowledge and provide the best possible care.

This study has enabled the knowledge bases of Community Matrons to be more clearly understood, which will inform curricula for advanced nurse practitioners and policy for long-term development of the role.
Introduction

The NHS Improvement Plan (DH, 2004) described a new clinical role for nurses, aimed at providing a comprehensive service for individuals living with a long term health condition. These new Community matrons were envisioned as being able to: “act as search engines in human form, … help[ing] people to find their way through all the facets of NHS care” (John Reid /06/04). Subsequent government policy on supporting people with long term conditions (DH, 2005a) introduced the roles of case managers and Community Matrons (with advanced clinical nursing skills) across the country. Case management forms the focus of managing care for people with long term health conditions and Community Matrons and case managers are expected to identify patients with long-term health conditions at risk of repeated hospital admission and support them to live independently and exercise personal choice, thus empowering them to manage their condition and remain at home. This involves providing these individuals with more timely interventions, closer to home and improving their accessibility to other services and agencies, thus preventing their condition deteriorating and reducing the number of unplanned hospital admissions.

Levels of patient care

The Department of Health (2005a) identified that patients with long term conditions required differing levels of care depending on the stage of the condition and whether they had multiple conditions. The majority of individuals require help and support to develop the 'knowledge, skills and confidence' to self care (see figure 1, level 1).

![Figure 1 The Kaiser Permanente Health Care Model (adapted from DH, 2005a)](image-url)
A smaller proportion of individuals require disease management and support from multi-disciplinary teams (see figure 1, level 2). A small minority of individuals have complex, maybe multiple, conditions, and are, or are at high risk of becoming, high intensity users of unplanned secondary care (see figure 1, level 3). These individuals need case management by a Community matron or an expert practitioner and estimates suggest there are about 50 such people per GP practice.

For experienced nurses undertaking this role, there are significant differences between working in hospitals and working in the community. These have been identified as:

- Patients in the community are in control of all decisions affecting their health and well-being
- Most treatment, health maintenance and care will be carried out by service users and their carers
- There are multiple systems and infrastructures supporting the delivery of health and social care, rather than a single hospital infrastructure
- Community practitioners will often have to make rapid clinical and professional decisions without the support of their colleagues

(adapted from DH, 2006 p 4)

There is currently very little evidence about how the Community Matron role is actually developing in practice (Cubby & Bowler 2009). Although recent studies have shown that patients' feel community matrons feel improve their quality of life and increase their confidence in managing their long term conditions (Sargent et al. 2007; Wright et al. 2007), reduce their reliance on hospital care (Leighton et al. 2008) and provide support for the patients' carers (Sargent et al. 2007; Brown et al. 2009) there is still debate about how effectively community matrons using a case management approach can reduce the number of hospital readmissions for patients on their caseload (Hutt et al. 2004; Gravelle 2007; Leighton et al. 2008), a key Government objective. Community Matrons work within the context of local Health Trusts and Primary Care Trusts and they liaise with a wide range of other medical, health and social service organisations and professionals. Each of these contacts will have an understanding of the role and range of expertise of the Community Matron. In addition, given the long-term nature of their conditions, many service users and their carers will have acquired both tacit and explicit knowledge about both the condition and their own care requirements. Some service users may have taken part in the NHS Expert Patients Programme (DH, 2001) established in 2002 to help people develop skills to manage their condition better on a day-to-day basis.

**Competency Framework**

As the Community Matron role was new, individuals were appointed with the understanding that they did not initially possess all the skills and knowledge required to develop a Community Matron service in their area. Consequently, a number of documents were produced to provide national guidelines and frameworks to support development of staff (DH 2005a, 2005b, 2005c, 2006, Bassett et al. 2007).

The case management competencies framework (DH 2005) outlines the knowledge and skills of both community matrons and case managers. The competencies are grouped into areas of practice but only Community Matrons are required to have a nursing qualification and to demonstrate competence in Advanced Clinical Practice, which encompasses a range
of advanced nursing skills (Figure 2). The framework is designed to aid recruitment and selection, identify development needs and help to commission education and training as necessary. To date, there has not yet been an in-depth study of the types of knowledge that underpin the role: how these types of knowledge are perceived by other professionals and service users/carers, and how the understandings, perceptions and expectations of significant stakeholders affect practice.

**Figure 2. Complexity of Community Matron practice**

**Background to the study**

This small scale research project took place in one city in the south of England, where there were established Community Matrons and a social worker for Long Term Conditions, and where an expert patient programme had been initiated but not continued.

The first two Community Matrons in this city were recruited to their posts in 2004, when there was little known about the Community Matron role nationally, making the city an early adopter of the Community Matron initiative. The role was envisaged as a leadership role with a clinical focus. A part-time secretary and a part-time social worker were also employed on a 12 month pilot scheme, however, though said to be successful, these posts were not continued after the pilot ended. By the time the interviews took place most of the Community Matrons had been in post for 15 -18 months.
Aims and Objectives

The aim of this project is to investigate the reality of the role of Community Matron and to examine the nature of the knowledge bases - tacit, experiential and formalised - from which practice is being developed. The project aims to produce an in-depth case study that relates the research findings to key literature and other data on tacit and experiential knowledge and competencies. It explores different ways of knowing about long-term conditions and how perceptions and expectations about their knowledge affect the practice of Community Matrons. By gathering accounts of practice and types of knowledge, and by mapping networks of understandings and expectations, it will inform the development of practice and teaching and learning in this area.

The learning generated from the project will be made available to other groups via a seminar and publications. The outputs will include schematic representations of the reality of networks and knowledge/information flows as well as written descriptions.

Objectives:

To explore:
- The skills base, formal training /competencies, tacit knowledge and identified learning requirements of Community Matrons in two practice settings in a new city,
- Understanding of the Community Matron's role and knowledge base by key stakeholders including relevant professionals, service users and carers,
- Knowledge exchange between these participants, and
- The relationship between different understandings of 'knowledge' about long term conditions, and the practice of the Community Matron.

To identify:
- The teaching and learning needs associated with the development of the Community Matron role

Methodology

The methodology was designed to produce an in-depth case study of the Community Matron role by taking a 360° view.

Participants

A convenience sample comprising 6 community matrons was used in this study. Potential participants, comprising eight Community Matrons employed across the city, were sent a letter inviting them to participate and an information sheet, which provided further details about the study. Six of the eight Community Matrons (5 female and 1 male) agreed to participate. These participants had practised as nurses for several years before becoming Community Matrons: the majority had been district nurses, though one had been a Health Visitor for older people and another an Intermediate Care nurse.

Data collection
Semi structured interviews were undertaken with each participant in a confidential setting, using an interview guideline of questions. The interviews, which were between 1 hr and 1 hr 30 minutes in duration, were digitally recorded and transcribed verbatim.

**Ethical considerations**

Ethics approval was gained from the Open University Human Participants and Materials Ethics Committee and the NHS Oxford COREC to enable the research, which involved NHS staff and patients/service users, to be carried out at more than one NHS Trust. Submission required the prior development of some of the essential project documents, including letters of introduction, information sheets, consent forms, and interview schedules for each category of interviewee. The COREC committee initially deferred giving approval for the project until specific alterations were made to the introduction/information/consent forms including:-
the use of a new format that was introduced after submission of the original application;
developing professional variations of each document, providing further written assurances about confidentiality and submitting an independent peer review of the project, which was carried out by Professor Christine Webb, Editor of the *Journal of Advanced Nursing*.

Prior to each interview commencing, interviewees were given an opportunity to seek clarification about any aspects of the study detailed on the information sheet and asked to sign a consent form. The information sheets informed potential participants that they had the right to withdraw from the study at any point without consequence and their attention was drawn to this as part of the process of gaining consent.

**Data analysis**

The interview transcripts were analysed, using thematic analysis, to identify emergent themes (Holloway and Wheeler 2010, p 204). This analysis was carried out by one researcher and the emergent themes confirmed by the other two researchers independently to triangulate the data.

Deferral of approval from the committee delayed the start of the project by a number of months, which meant that the researchers missed their scheduled periods for working on the project due to other commitments. Subsequently, this delayed completion of the full project. However, the researchers have sufficient data to write a paper concentrating on the Community Matron role. The planned semi-structured interviews with General Practitioners (GPs), district nurses and other relevant PCT staff and hospital colleagues, the Community Matron’s supervisors and mentors, service users and carers were not completed as it was surprisingly difficult to engage health care professionals in other roles than Community Matron, with the project. Several potential participants replied that they did not have time available to participate in the project. It was also difficult to identify suitable service users/carers to approach, which may have been due to the severity of the long-term conditions of people on the Community Matron case loads.

**Findings**

**Differences and similarities between practice-based and city-wide service**

Community Matrons in the city operate under two different models, in one model Community Matrons provide a service across the city that is linked to several GP practices, in the other model Community Matrons are linked to primarily to one GP practice and also give limited...
support to another practice nearby. The role of the Community Matrons in both models is to support patients and their carers to manage their own care and to draw in other agencies as appropriate. Each Community Matron has a small case load (between 35 and 50 patients), reflecting the complexity of their practice, and they build this case load by identifying patients with complex long-term health conditions at risk of repeated hospital admissions.

Community Matrons in the city-wide service are case-finders; proactively seeking out patients by visiting the hospital daily to ascertain the health status of current patients, in particular referring to the hospital data base and using the Patients at Risk of Re-hospitalisation (PARR) case finding tool (Kings Fund, 2005) to identify potential cases. Community Matrons in this city-wide service have thus pre-empted Lawlor’s (2009) recommendations for ensuring patients with complex problems are referred to Community Matrons. They also accept referrals from GPs and District nurses. Patients that don’t meet the criteria for care by Community Matrons are referred to more appropriate services.

The practice-based Community Matrons have a GP caseload and visit the surgery each day to find out who had been admitted to hospital in the last twenty four hours. They also visit the hospital to ensure all people on their case load are identified as inpatients. Referrals come from GPs, family, carers and social agencies, and occasionally patients refer themselves.

**Education for the role – formal learning**

All the Community Matrons felt their previous experience helped them in this new role and that it was a natural extension of their previous roles, although their backgrounds were not identical. They also felt that experiential learning (learning on the job as they put it) becomes increasing important as they hone their practice skills and embed formal knowledge into their practice. These nurses then bring to their new role a wide range of skills but, in their own views, require further knowledge and skills to undertake the role effectively.

**Perceived knowledge gaps of Community Matrons**

As pioneers of this new role, the two city-wide Community Matrons appointed initially did not have a clear idea as to how to go about gaining the necessary knowledge and skills to fit them for the role. As one of them explained:

‘It was a huge challenge and it was very much – nobody really knew what we were supposed to be doing or how we were supposed to be doing it or anything really but we sat under Intermediate Care which was a joint service which was very good and we sort of devised a pilot. … We wanted to know … how are we going to generate the information we need to produce reports…? What sort of training are we going to do? Then in the summer of 2005 we were asked to join a university as part of another pilot.’

Community Matron Davella* from city-wide service

(*pseudonyms have been used to protect participants’ identities)
This pilot course was a Post Graduate Certificate for Clinical Case Management for Long-Term Conditions, which provided Community Matrons with a basis of skills and knowledge. As the Community Matron above put it:

‘... that was really my basic education for redesigning myself as a Community Matron. I also found that you need a lot disease management so I did the COPD and Coronary Heart Disease courses at a national centre. I also did my non-medical prescribing…’

Community Matron Davella* from city-wide service

This pattern of formal education was followed by the other Community Matrons as they were appointed into the City-wide service and they said that this formal preparation gave them confidence to carry out the role. They described how when visiting patients they were able to use the skills of history-taking, physical examination, differential diagnosis and the knowledge and skills to prescribe medication such as antibiotics.

These skills were stated by all respondents to be of prime importance and were described by all as “advanced practitioner skills”. This was an umbrella term used to encompass those skills that were acquired following initial education for registration and include: nurse prescribing, advanced history taking, differential diagnosis; management skills and research skills to give theoretical underpinning to decisions. In addition, knowledge of specific conditions was required as well as, written and verbal communication skills e.g. report writing. All these were seen as essential for the community matron role and these particular skills were learned through undertaking modules at university, either at diploma or Masters level. In addition, modules on the management of specific long-term conditions and nurse prescribing courses augmented the formal knowledge gained on the advanced practitioner skills programme.

**Being autonomous learners**

Each Community Matron felt they needed to be an autonomous learner, identifying their learning needs and prioritising them as they were very aware they could not acquire all the necessary skills concurrently while also carrying out the role full-time:

‘You have to prioritise… I decided to develop my clinical skills and to become a qualified nurse-prescriber first… now I am acquiring case management skills’

Community Matron Davella*, city-wide service

‘We were basically starting from scratch, there was no consistency across the country… I improved my clinical assessment skills… and learned about specific diseases… otherwise I would not happy to prescribe’

Community Matron Alan*, city-wide service

**Education for the role - informal learning**

Community Matrons identified three areas of informal learning and knowledge acquisition that are shaping their service; learning in practice, developing good knowledge and understanding of local services and the role of patients’ knowledge about their condition
Learning in practice

Initially, Community Matrons sought guidance from other Community Matrons and attended conferences in order to learn about good practice and ways of working but they also recognised the importance of continuing to learn in practice or ‘on the job’:

‘At the start when we took on the roles [I attended] Community Matron courses, long-term conditions courses. [Now] I learn on the job, I ask other practitioners for the information I need … we also have lots of in-house training. I have got the opportunity to learn within the building and meeting up with staff and doctors out at the houses’

Community Matron Leanne*, GP Practice

‘I am learning sort of on the job and on the case, case by case really… you have a patient in that situation and you jolly well learn very fast. With the help of those around you, you are not going in blindly but you learn. I learn with patients…’

Community Matron Peter*, GP Practice

‘I think practically speaking there are lots of things that you can learn on the job as you do with anything you know and you develop into any role that you are learning as you go along.’

Community Matron James*, city-wide service

‘Day to day learning from people, all the time talking to people,

Community Matron Joy*, city-wide service

One skill mentioned by several of the Community Matrons that was learnt through ‘doing the job’ rather than in formal education for the role was leadership:

‘I mean you can improve your clinical skills and it is quite easy to get training for that, but actually leadership and how to put your case across and how to use change management skills and things, that is not so easy to pick up really … because I started when I did and because I was instigating a brand new service, it was more a case of if you like, I had been thrown into it and I had to sit on all these meetings of the high and mighty and get involved.’

Community Matron Davella*, city-wide service

Local Knowledge

Local knowledge about the area and the services available was seen as essential in providing high quality care:

‘I think sort of knowing the resources that are available and being able to utilise those in the right way…because we have that local knowledge we can get the services straight in’

Community Matron Alan*, city-wide service
‘once you have got a hang of what is available in the area, you can keep up with the changes but learning all that knowledge to start with is I would think would be difficult, it was certainly difficult when I first came here to work out how it all worked’

Community Matron Peter*, GP practice

This Community Matron who had previously practised as a health visitor maintained her work with community groups locally and combined this with her new role.

Developing good relationships with key players in the health and social care and voluntary sector was mentioned by all, this is especially important as it is can be difficult to manage the high workload:

‘I think you constantly, constantly try to build relationships with many professionals… but you may not be working with them regularly’

Community Matron James*, city-wide service

‘I know who to go for certain type of help…most of it is telephone referrals, thank goodness, because we wouldn’t fit it in’

Community Matron Leanne*, GP Practice

Patients’ and Carers’ knowledge

There was a difference in the level of awareness patients and their carers had about the patient’s condition. Across the city it was common for patients to have little knowledge, which contrasted with the high levels of knowledge seen by Community Matrons working in the GP practice:

‘The people I have been involved with are generally very ignorant about their condition… a lot of people don’t read the leaflets’

Community Matron Davella*, city-wide service

‘some of them are fantastic experts in their clinical condition, absolute amazing experts, and we learn from them as well and we will quite happily say to someone oh what does that mean because they will come out with a term that means nothing to us’

Community Matron Leanne*, GP Practice

Community matrons were also aware of their role in ensuring information acquired by patients was accurate:

‘In the advent of internet [you have to] make sure that they are filtering the information’

Community Matron Joy*, City-wide service

Becoming experts

There was perception by all the respondents that Community Matrons’ knowledge was different to that of District Nurses. For example:
I think it very much more an autonomous role in terms of your clinical practice compared to the district nurses role, so you have a lot more autonomy in terms of assessing patients, diagnosing patients and treating them. So I think you have to have increased knowledge quite considerably really.

Community Matron Davella *, City-wide service

…it is now moving into a different realms where as a District Nurse obviously I mean I was using all those skills before, but because I have now undergone some extra training so my awareness is different and my thought processes are different … I don’t think it is black and white anymore, … when you are dealing with somebody with multiple problems there are so many variables and so many differential diagnoses…

Community Matron James *, City-wide service

The Community Matrons therefore recognised that they needed to gain knowledge and skills to enable them to become experts in their role, and highlighted that this may be gained in a number of ways such as:

**Studying MSc modules**

‘You are expanding your knowledge as an expert… so you have to have some confidence that what you are doing is evidence-based’

Community Matron Joy*, City-wide service

**Attending a 5-day clinical skills course**

‘It gave me confidence, I don’t think it gave me knowledge as I think I already had [it] but I was worried that I hadn’t’

Community Matron Peter*, GP Practice

**Vicariously through discussion with colleagues**

‘She came back with some tremendous knowledge so I often tap her for that’

Community Matron Leanne*, GP Practice

**‘Pushing’ and ‘knowing’ the boundaries**

“Pushing the boundaries” and “knowing the boundaries of their knowledge and skills” was perceived to be an important feature of the Community Matron role. Pushing the boundaries included “thinking outside the box” which seems to mean lateral thinking and being able to take risks. One respondent describes how she feels she has moved on from where she was before taking on the Community Matron role; she is moving in a different direction but has to know her boundaries:

…you have to limit yourself about how far outside the box you can go because at some point there is something you can’t take on, or you make the referral, you pass it on to the right services and I think that is knowing where the boundaries are as well...

Community Matron Leanne*, GP Practice
Discussion

Contrary to the study of Drennan et al (2005), who reported that many Community Matrons were employed directly from acute hospital settings, the community matrons in this study all have community backgrounds. This finding supports Girot and Rickaby (2008), who found most students studying on the national pilot education programme to prepare for the Community matron role had community backgrounds. In addition, Community Matrons in this study saw moving from district nurse/intermediate care nurse to community matron as a natural progression in their career, a similar view to that posited by Pollard (2005). They all felt this previous experience was important, as they built on their existing knowledge and skills to develop their new role, although some of them had underestimated the learning needed to meet the demands of the role. They perceived their previous training and experience had enabled them to develop competence in ‘reflecting-in’ and ‘reflecting-on’ practice (Schön, 1987) and that they used these skills to identify their own training needs and personal acquisition of formalised knowledge.

Previous studies have discussed the importance of formal learning in developing the Community Matron role through engaging with specific programmes of study such as the national pilot education programme (Girot and Rickaby 2008); individual MSc modules for diagnostic reasoning skills, patient assessment; or independent nurse prescribing (Banning 2009), but few have taken a holistic approach and explored broader ways of knowing. In common with other studies (Dossa 2009; Banning 2009), this study suggests Community Matrons certainly feel the role has broadened their knowledge and skills and that access to appropriate training and education is vital. Community Matrons on the national pilot programme had mixed views as to whether or not the programme supported them to develop their role (very well/well; n=14; not very well/not at all, n=11). Those who were dissatisfied with the programme primarily felt they needed more advanced skills development and more support in their work-based learning (Girot and Rickaby, 2008). In contrast, Community Matrons in this study emphasized the role of learning ‘on the job’ - learning that is not linked to formal programmes of study, which may explain their increased satisfaction with their education and training. Community Matrons in Girot and Rickaby’s study felt that their organisations were not always supportive of work-based learning, which may have limited their ability to develop complex skills (Spouse 2001). However, Community Matrons in this study felt well-supported, particularly those linked to a GP practice, and that they were provided with many opportunities to learn from specialist nurses and GPs specialising in particular long term conditions such as COPD or heart disease.

Community Matrons also felt having good local knowledge was important as it enabled them to bring appropriate services to assist patients very quickly, thus supporting previous studies (Banning 2009), but this study also highlighted the difficulties one participant encountered when moving to a new locality, reinforcing the role of local knowledge.

Community Matrons in this study felt they also learned from patients on their caseload, some of whom were very well-informed, a finding that has not been reported in any of the previous studies of Community matron role development. However interestingly, in contrast to other studies (Girot and Rickaby 2008; Cubby and Bowler 2009), Community Matrons in this study did not allude to mentors playing a role in their education or training, although they
acknowledged the importance of networking with other Community Matrons in developing the services.

Also, the Community Matrons felt they had developed leadership skills through being thrown into the role of developing a new service that bridges primary and secondary care, supporting Lillyman et al’s (2009) findings that district nurses are successfully developing these skills and belying Murphy’s (2004) assertion ‘that there may be few community matrons who are ready to project the necessary personal gravitas and exercise the clout necessary for skilful negotiation with GPs, hospital consultants and social care providers’.

Although, unlike the Community Matrons in this study, not every Community Matron feels confident to ‘push the boundaries’, with some preferring instead to work within their remit (Banning 2009), Community Matrons in all of the studies published to date perceive they are engaging in new ways of thinking. They believe that this is primarily brought about by studying at Master’s level, thereby supporting Ashworth et al’s (2001) view, also cited in Banning (2009), that master’s level education is about ‘equipping nurses with the competencies to pioneer new nursing roles and lead the development of new services’. This was especially necessary for the first tranche of Community Matrons who were appointed on the understanding that they did not yet have all the skills required for this new role.

**Conclusions**

Community Matrons in this study perceive themselves as autonomous practitioners, who identify their own training needs and are responsible for their personal acquisition of knowledge and skills. They enhance their knowledge and skills through formal and experiential learning once in post but they also feel that past clinical experience, community experience, communication skills and life skills are equally important in developing this role. Community Matrons also stressed the importance of distributed learning and knowledge sharing, both with each other and with other healthcare professionals, in providing high quality clinical care to enable people with complex long-term conditions to stay at home, thereby reducing the risk of them being re-admitted to hospital.

**References**


Lawlor P. (2009) Referring patients with complex problems to community matrons *Primary Health Care* 19(10) [see also Corrected version Primary Health Care 2010. 20(1)]


**Impact**

The findings from this project have informed thinking in the Pre-registration Nursing Programme, specifically contributing to materials for KYN291, *Developing Adult Nursing Practice* in relation to caring for people with long-term conditions. In addition, in future the findings may inform the developing post-qualifying Nursing provision, in particular the new Leadership pathway.

Once published, these findings may also inform Nursing curricula at other Higher Education Institutions and policy within the NHS.

**Deliverables**


Consent forms etc for gaining ethical approval

Paper being prepared for submission to the *Journal of Advanced Nursing*

**Dissemination**

An end of project seminar will be held as part of the dissemination. This will be open both to the research participants and to other CETL researchers.

**Commentary**

Practice-based professional teaching and learning is central to the Dept of Nursing curricula, and it is vital this is underpinned by research and scholarship. This project gave an
opportunity to explore the transfer of knowledge between the various health care professionals responsible for the continuing care of people with long term conditions, which may or may not be co-ordinated by a Community Matron. The Community Matron role is relatively new. This project contributes to knowledge of this emerging role, and other emergent nursing roles, and informs health care professionals continuing development post registration.

This was seen by the project team as an exciting opportunity to undertake research and to enhance our scholarship though participating in the PBPL community. PBPL has offered an interesting programme of events which we found very stimulating and have benefitted from attending. For me, the highlights include the workshops lead by Etienne Wenger, seminar given by David Boud, and the special interest groups. I especially valued the opportunity to discuss research with David Boud in the small discussion group following his seminar and the two day special interest group residential away-days.

The PBPL CETL has been very influential in enabling research related to issues associated with teaching and learning in the professional curricula at the OU. It has also enabled research into professional issues that will inform our evolving curricula – e.g. understanding how nurses develop emotional resilience, or make transitions from student to registered nurse. It is a shame that CETL funding is coming to an end. I feel it would really benefit the OU to continue to support this initiative through additional funding and showcasing the findings.

In undertaking this project we had underestimated the time it would take to secure COREC approval to enable us to commence data collection. Also, we were surprised that although Community Matrons were pleased to participate in the project, other health professionals were much more reluctant. This slowed down the project considerably and involved the team in additional work.

We intend to continue to contribute to PBPL events and would like to have an opportunity to proffer ideas for future events. We would also welcome the opportunity to present our research.

Verina Waights. May 2010