

Caring for people with long term conditions:

an education framework for **community matrons** and **case managers**



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For Recipient's Use	



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Foreword

Fifteen million people in England report living with a long term condition. While many are already receiving quality health and social care, there is a need to ensure this care - particularly for those with the most complex conditions - is properly co-ordinated.

The government has therefore set a national Public Service Agreement (PSA) target:

'To improve outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk, and to reduce emergency bed days by 5% by 2008 through improved care in primary and community settings.'

Meeting the different elements of this target will require significant changes to traditional patterns of care delivery. As set out in the White Paper Our Health, Our Care, Our Say (published January 2006), health and social care professionals will need to work closely together to provide a joined-up, proactive case management service that takes a holistic view of the needs of individual service users. Some of these professionals - known as **community matrons** - will also provide advanced nursing and clinical care in the home.

A collaboration between the NHS Modernisation Agency and Skills for Health has published the Community matron competences framework, (2005), which defined the knowledge and skills for **community matrons** and other health and social care professionals performing a case management role. For **community matrons**, meeting these competences will mean working at a level commensurate with the advanced practice requirements set by the Nursing and Midwifery Council (NMC). For both **case managers** and **community matrons**, the framework will inform the development of a personalised learning plan that builds on their existing knowledge and expertise and responds to any identified development needs.

This document explains how commissioners and providers can use the competences to develop appropriate education and training. The guidance set out here is based on evidence drawn from a number of pilot programmes. It:

- encourages partnership and collaboration between higher education institutions (HEIs) and between HEIs and the NHS
- promotes non-traditional methods of learning
- shows how nurses who want to become **community matrons** or **case managers** can learn in the workplace and build on the competences they already have
- explains that becoming a **community matron** need not mean following a full masters programme.

It is unusual for this level of guidance to be available at the inception of a new role. We hope that this document will enable commissioners, providers, employers and **community matrons/case managers** to work together to develop the new role into one that makes a positive difference to the lives of people with long term conditions.



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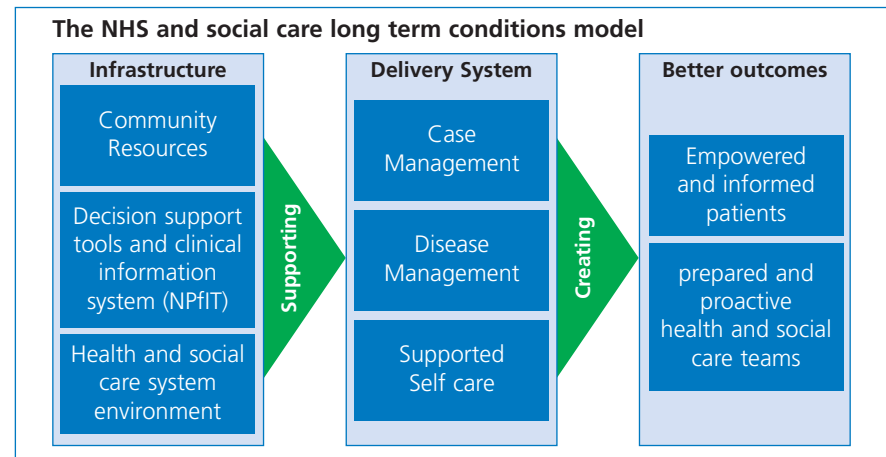
Introduction

This document provides a framework for commissioners and providers of education and training for **community matrons** and **case managers**. It is designed to help ensure that the education and training these practitioners receive enables them to provide more effective care for people with complex long term conditions. The education framework complements the case management competences framework for the care of people with long term conditions. Much of the content of the document will also apply to health and social care professionals working as **case managers**.

The education framework on page 08 is based on evidence drawn from a number of pilot programmes, including the long term conditions programme being run at Sheffield Hallam University. Detailed case studies of all the contributing programmes are available on the enclosed CD.

Background

In January 2005, the Department of Health published Supporting people with long term conditions: an NHS and social care model to support local innovation and integration. The NHS and social care model (to the right) aims to help health and social care organisations take a structured and systematic approach to improving the care of people with long term conditions. The recommended route to delivering a systematic approach is to utilise multi-professional teams and integrated patient pathways, ensuring closer integration between health and social care. Different interventions should then be used for people with different degrees of need. The model sets out a delivery system that matches care with need. You can read the document in full on the enclosed CD.



Effective case management is a key element of the model. Evidence shows that intensive, ongoing and personalised case management can improve the quality of life and outcomes for people with the most complex long term conditions. A case management approach anticipates, co-ordinates and joins up care, reflecting these peoples' intricate health and social care needs. This framework aims to help create a workforce that can deliver this approach.

Achieving this also calls for the creation of a new role: the **community matron**. While many health and social care professionals are already acting as effective **case managers**, those individuals with very complex and intensive clinical needs will require input from a **community matron** - a qualified nurse who can provide advanced nursing and clinical care as well as effective case management.

Community matrons - and **case managers** - will need to use a wide range of skills and techniques. To support their development, the Modernisation Agency and Skills for Health published the case management competences framework for the care of people with long term conditions (2005). The framework, which is underpinned by the principles set out in the NHS and social care model for people with long term conditions, sets out all the competences associated with case management and draws a distinction between those needed by **community matrons** and those needed by **case managers**. It has an important role to play in the identification and assessment of education and training needs.

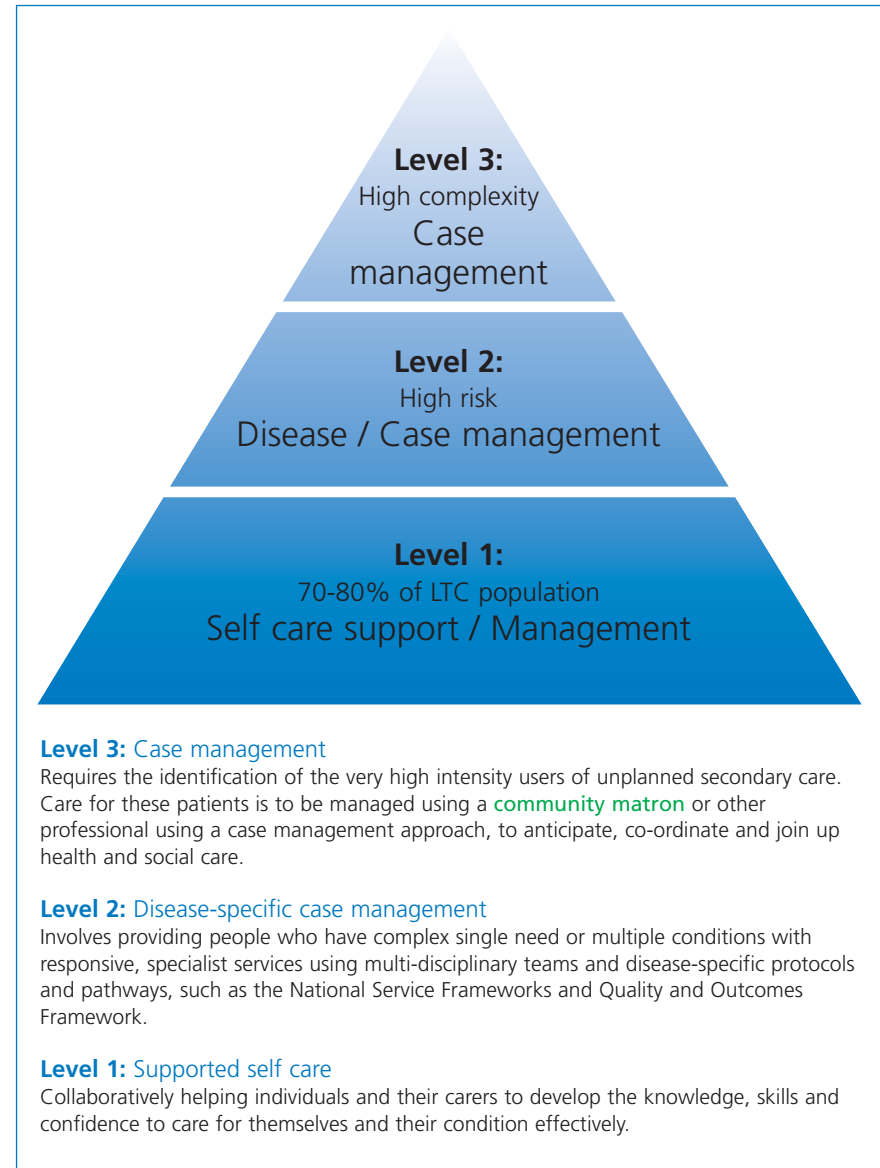
What is case management?

There is no one agreed definition of case management. However, the case management competences framework (provided in full on the enclosed CD) clearly sets out what it means in the context of long term conditions. According to the framework, **community matrons** and **case managers** should proactively identify the most vulnerable people, then work in partnership with the individual, their carers and other relevant health and social care professionals to co-ordinate and manage their care. In this way, they can anticipate and deal with problems before they escalate, minimising the impact on health services and the individuals well-being.

Identifying different degrees of need

The diagram to the right shows how different interventions should be used for people with long term conditions, depending on their degree of need. People in Level 3 - those with the most complex and intense needs - are most likely to need case management by a **community matron**, who can provide advanced nursing and clinical care. There may also be a small number of patients in this group whose complex single condition or social care needs mean that, while they do not need advanced clinical care, they do need intensive case management. **community matrons** and **case managers** will need to use their professional judgment to correctly classify individuals at the margins of each category.

For more information about these levels and the NHS social care model on page 03, see the enclosed CD.



Identifying the most vulnerable people

Part of the role of **community matrons** and **case managers** will be to help identify people in their health communities who have long term conditions through professional, self and carer referrals. These will be people who are very high intensity users of secondary care (VHIU's). **Community matrons** and **case managers** will do this by working in partnership with other people who are responsible for long term conditions, and using risk stratification systems such as the Patients at Risk of Re-hospitalisation (PARR) risk prediction tool.

PARR was designed to provide the NHS with a more accurate method of identifying those people most at risk of being re-admitted to hospital. It is the first part of a package of predictive case-finding software that the Department of Health and the NHS have commissioned from the King's Fund, New York University and Health Dialog Analytic Services. The tool uses emergency hospital admission as a 'triggering event', then applies an algorithm based on a range of diagnostic information and hospital episode statistics (HES) to produce a risk score for the likelihood of readmission in the next 12 months.

The tool is designed to help local health communities identify their high risk patients, then use a case management approach to provide personalised, proactive, co-ordinated and joined-up care in a community setting. It can be used in conjunction with local information to model the impact and cost of case management services. The PARR tool is available free via the King's Fund website at www.kingsfund.org.uk

The enclosed CD includes a review of the literature on risk identification.

Roles and responsibilities

Community matrons

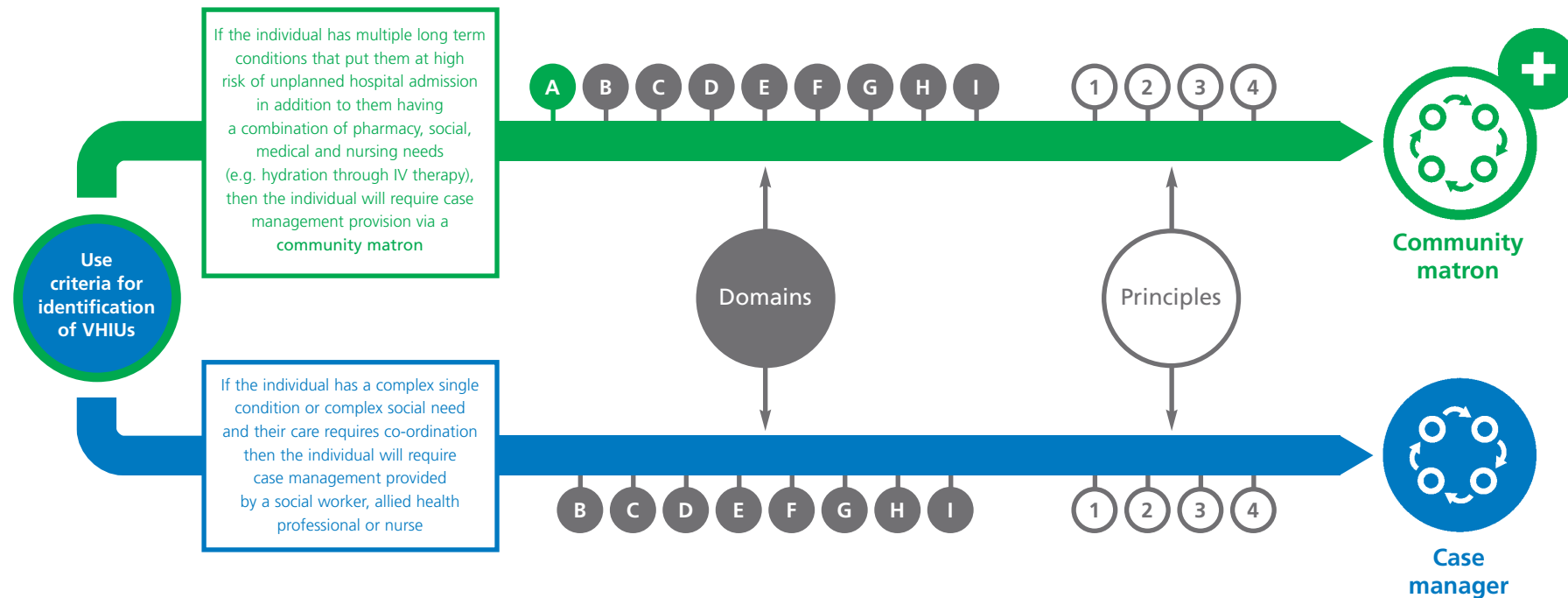
Community matrons will provide a full case management service, typically for a caseload of around 50 very high intensity users. They will also provide clinical and nursing care in the home. Three of the most common reasons for unscheduled hospital admission among the most vulnerable group of people are respiratory problems, dehydration and urinary tract infections. A highly skilled nurse can treat all these conditions in the home.

Case managers

A **case manager** will usually be a qualified nurse, a social worker or an allied health professional. They will work with individuals who have a dominant complex single condition and intensive needs, and whose care requires co-ordination. Their role will include working with these individuals, their carers and other health and social care professionals to develop a personalised care plan. They will also be responsible for planning, monitoring and anticipating the changing needs of these individuals, and co-ordinating their care across all parts of the health and social care system.

The case management competences framework

The case management competences framework brings together the range of knowledge and skills required by **community matrons** and **case managers**. The framework groups the competences into domains (or areas of practice) labelled A-I. **Community matrons** will need to demonstrate competence in all the domains. **Case managers** – who do not provide advanced nursing care - will need to demonstrate competence in domains B-I.



Using the case management competences framework

You can use the case management competences framework to help recruit practitioners with appropriate knowledge and skills, and to assess existing practitioners' current level of knowledge and skills. You can then carry out a skills gap analysis in order to identify the areas in which you need to commission education and training. The education framework on the next page sets out an evidence-based approach to effective commissioning.

The case management competences framework reflects and complements the Career Framework for Health, with its focus on flexibility and transferable, competence-based skills.

Domains

Select relevant competences from the following domains appropriate to the role chosen:

- A** Advanced Clinical Nursing Practice
- B** Leading Complex Care Co-ordination
- C** Proactively Manage Complex Long Term Conditions
- D** Managing Cognitive Impairment and Mental Well Being
- 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

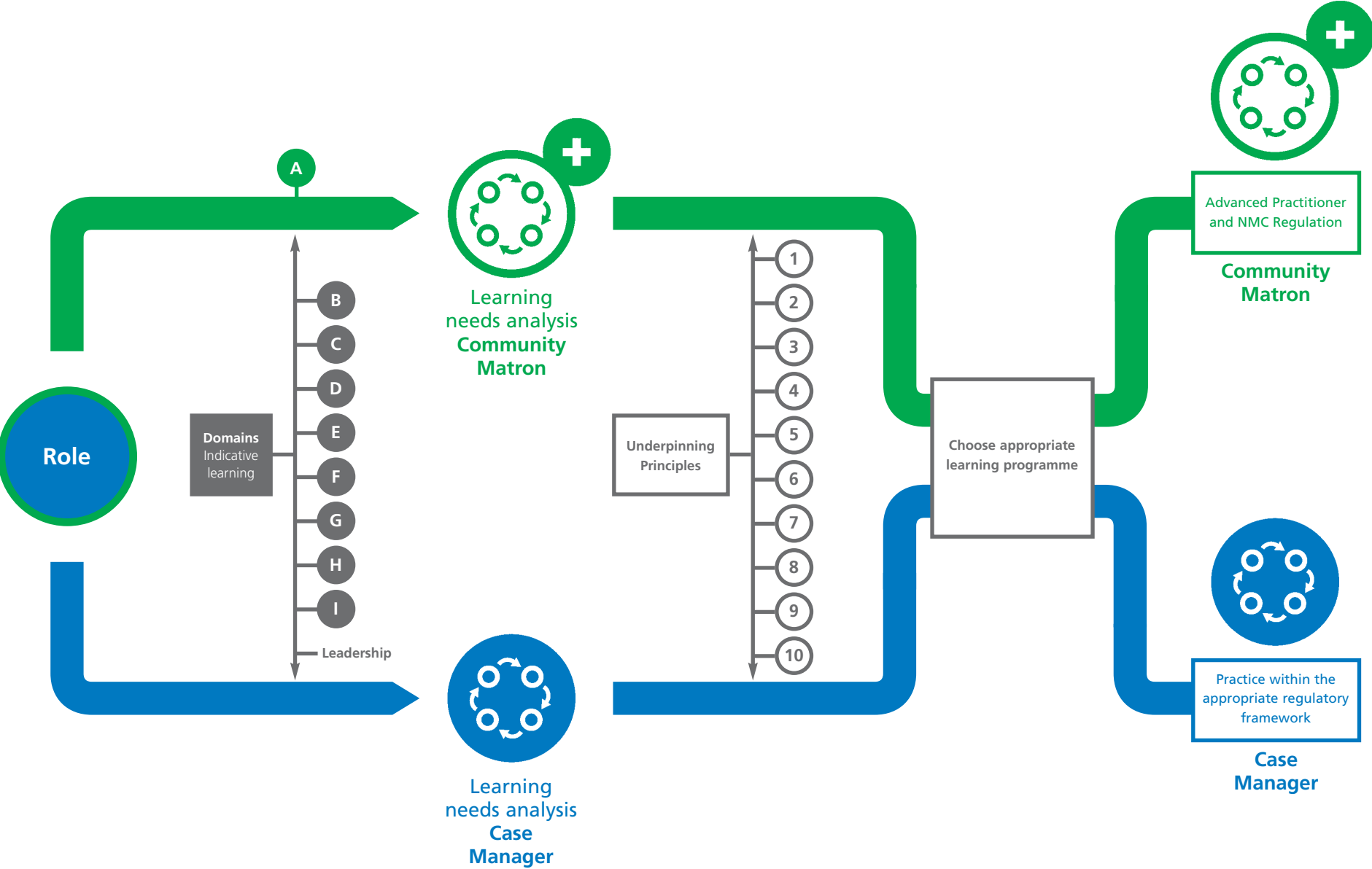
The case management competences framework and full competences are enclosed on the CD.

Principles

Principles that should be applied when using the competences relevant to the role chosen

- 1 Additional Competences Relevant to Post
- 2 Acquired Through Work Based Learning
- 3 Accommodate Varied Levels of Practice
- 4 Leadership Across Health and Social Care

The community matron and case management education framework



The community matron and case management education framework

The education framework shown in the diagram to the left is based on evidence drawn from a number of pilot education programmes for **community matrons** and **case managers**. The framework is designed to:

- raise standards of health and social care for people with long term conditions by supporting health professionals to develop appropriate and consistent knowledge and skills
- ensure that the contribution of higher education institutions (HEIs) to workforce development is timely, reflects service needs and is based on competences that are explicitly linked to local delivery plans, service improvement plans and Agenda for Change
- encourage collaboration and partnership between education commissioners and providers.

This section of the document begins by looking at the overall education and training requirements for **community matrons** and **case managers**, and providing an overview of the knowledge and skills required under each of the domains in the case management competences framework. It then goes on to explore the framework's Underpinning Principles.

See the enclosed CD for detailed information on the pilot education programmes.

Education and training requirements

Community matrons will need to demonstrate competences in domains A-I. The competences in domain A closely reflect the requirements set out by the NMC for advanced practitioners. Because the role of **community matrons** involves providing advanced nursing and clinical care, they will need to demonstrate these domain A competences through masters' level practice. However, the NMC has agreed that this does not mean that prospective **community matrons** will need to follow a full masters' programme. It is very likely that many **community matrons** will already have much of the knowledge and skills required to undertake the role. **Case managers** will not need to demonstrate competences in domain A.

The NMC Implementation of a framework for the standard for post registration nursing and the mapping of the associated competences to the KSF can be found on the enclosed CD.

The competences in domains B-I can be practiced at various levels. Many practitioners who are already working with people with long term conditions will already have some or all of these competences. If they need to acquire new competences, they should aim to do so at a level that reflects the needs of the people they are caring for. **Case managers** - particularly those who are working independently and autonomously - who are caring for people with the most complex needs may need to acquire some or all of the competences in domains B-I at masters level. This level of competence can be achieved through practice and work-based learning.

Both **community matrons** and **case managers** work in multi-professional and multi-agency settings. They therefore need a high level of communication, problem-solving and decision-making skills. They must be able to manage risk appropriately, and to take responsibility for their own decisions.

Community matrons will need to draw on the relevant social, biological and epidemiological sciences. They will need a sound understanding of change management, organisational development and emotional intelligence. This will also be true for some **case managers**.

The competences within domain H focus on end of life care. This will support the End of Life programme in extending the boundaries of palliative care provision for all patients, regardless of diagnosis, and complement the provision of long term care by enabling more patients to live and die in the place of their choice.

Required knowledge and skills

The case management competence framework clearly sets out the knowledge and skills required to undertake the roles of **community matrons** and **case managers**. This information can be found on the enclosed CD.

A brief summary of the knowledge and skills within each of the domains is presented on page 10 and 11.

Domains

Indicative learning content for each domain

- A** Advanced Clinical Nursing Practice
- B** Leading Complex Care Co-ordination
- C** Proactively Manage Complex Long Term Conditions
- D** Managing Cognitive Impairment and Mental Well Being
- 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

A Advanced Clinical Nursing Practice

- Advanced clinical assessment skills
- Advanced risk assessment and appropriate management of risk
- Advanced ability to use information in undertaking assessments, clinical decision-making and diagnosis
- In-depth knowledge and understanding of the presentation, progression, pathophysiology and prognosis of common long term conditions
- In-depth knowledge and understanding of therapeutic interventions, including relevant pharmacology and medicines management
- Advanced communication and interpersonal skills
- In-depth knowledge of and ability to apply relevant legislation, and full understanding of the ethical issues involved in caring for people with long term conditions
- Sophisticated application of holistic person-centred approaches to care.

B Leading Complex Care Co-ordination

- Advanced skills in use and management of knowledge
- In-depth knowledge and understanding of health and wellbeing issues for people with long term conditions
- In-depth knowledge and understanding of and ability to manage interdisciplinary and team-based approaches to care
- Knowledge and understanding of government policy and guidance on long term conditions
- Knowledge and understanding of service and resource procurement and management
- Skills in identifying and protecting those at risk (particularly in relation to adult abuse), and caring for and supporting those individuals who have suffered abuse.
- Advanced communication and interpersonal skills
- Sophisticated application of holistic person-centred approaches to care
- In-depth knowledge of and ability to apply relevant legislation, and full understanding of the ethical issues involved in caring for people with long term conditions.

These Domains relate to the education framework shown on page 08.

C**Proactively Manage Complex Long Term Conditions**

- Knowledge and understanding of the impact of socio-economic and personal circumstances on people with long term conditions
- In-depth knowledge and understanding of the impact of lifestyle choices on long term conditions
- Skills in managing clinical events, including risk assessment and appropriate management of risk
- Advanced skills in managing and facilitating patient and carer education
- In-depth knowledge and understanding of and ability to manage interprofessional and interagency working
- In-depth knowledge and understanding of and ability to support the care of individuals in the home environment

D**Managing Cognitive Impairment and Mental Well Being**

- Knowledge and understanding of sources of information on mental health and related services
- Skills in the assessment of mental health needs, including risk assessment
- Knowledge and understanding of physical, behavioural, emotional and psychological indications of mental health needs
- Knowledge and understanding of counselling and psychological support methods
- Skills in interpreting responses to long term conditions, including recognising the signs of depression
- In-depth knowledge and understanding of diversity, discrimination and stigmatisation
- Knowledge and understanding of therapeutic interventions
- Advanced communication and interpersonal skills.

E**Supporting Self Care, Self Management and Enabling Independence**

- Skills in partnership working with patients and carers
- Knowledge, understanding and application of cognitive behavioural therapy techniques
- Advanced conflict and dispute management skills
- In-depth knowledge and understanding of community resources and support networks
- Advanced skills in empowering patients and enabling self care
- In-depth knowledge and understanding of self-advocacy
- In-depth knowledge and understanding of the impact of long term conditions on everyday living
- Knowledge and understanding of individual rights
- Advanced skills in facilitating participation and independence
- Advanced change management skills
- Advanced teaching, learning and coaching skills
- In-depth knowledge and understanding of the impact of lifestyle choices on long term conditions.

F**Professional Practice and Leadership**

- In-depth knowledge and understanding of professional accountability.
- In-depth knowledge and understanding of workforce development, professional development, supervision and appraisal.
- Highly developed reflective practice skills.
- In-depth knowledge and understanding of relevant clinical governance issues.
- Advanced leadership skills.
- In-depth knowledge and understanding of organisational development and change management.
- In-depth knowledge and understanding of the issues relating to personal and professional competence.

G**Identifying High Risk People, Promoting Health and Preventing Ill Health**

- Skills in analysing, interpreting and presenting public health data.
- Knowledge and understanding of evaluation methodologies and associated ethics.
- In-depth knowledge and understanding of social constructions of health and illness.

- H** **Managing Care at the End of Life**
- Knowledge and understanding of life stages and changes and losses associated with long term conditions
 - Knowledge and understanding of how individuals respond to distress
 - Skills in the care of the dying and bereavement care.

- I** **Interagency and Partnership Working**
- In-depth knowledge and understanding of collaborative and interagency working
 - Knowledge and understanding of performance review
 - Advanced conflict and dispute management skills
 - Advanced communication and interpersonal skills.

Leadership

The case management competence framework recognises that competences cannot themselves ensure effective practice. Both **community matrons** and **case manager** roles will contain significant elements of leadership responsibility hence all individuals will be required to combine the competences with well developed personal effectiveness.

Leadership of **community matrons** and **case manager** is one of the underpinning principles that should be applied when using the case management competences framework. More information about leadership across health and social care can be found on the the CD.

Underpinning Principles

Principles that should be applied when choosing the appropriate learning programme

- 1 Advanced practice
- 2 Learning methods
- 3 Recognising prior learning
- 4 Interprofessional learning
- 5 Mentorship and coaching
- 6 Organisational governance
- 7 Collaborative commissioning
- 8 Assessment of competences
- 9 Clinical Supervision and continuing professional development
- 10 Supporting experienced hospital nurses to move into community matron roles

These Underpinning Principles relate to the education framework shown on page 08.

The underpinning principles of the education framework

The principles that underpin the education framework are based on evidence drawn from a number of **community matron** and **case manager** pilot education programmes. These principles should be used when selecting relevant learning programmes.

1

Advanced practice

Community matrons, whose role involves providing advanced nursing and clinical care, must be equipped to practice at masters' level, and may need supported learning and development to achieve this. It is likely that many **community matrons** will already have much of the required knowledge and skills, and will not necessarily need to follow a full masters programme. Other forms of learning, such as work-based learning, are equally as valid and effective.

Because most **community matron's** caseloads will include people with very complex and intense needs, they are expected to work at a level that is commensurate with the definition of an advanced practitioner set out by the NMC:

Advanced nurse practitioners are highly skilled nurses who can:

- take a comprehensive patient history
- carry out physical examinations
- use their expert knowledge and clinical judgement to identify the potential diagnosis
- refer patients for investigations where appropriate
- make a final diagnosis
- decide on and carry out treatment, including the prescribing medicines, or refer patients to an appropriate specialist
- use their extensive practice experience to plan and provide skilled and competent care that meets patients' health and social care needs, involving other members of the healthcare team as appropriate
- ensure the provision of continuity of care, including follow-up visits
- assess and evaluate, with patients, the effectiveness of the treatment and care provided and make changes as needed
- work independently, although often as part of a healthcare team
- provide leadership
- make sure that each patient's treatment and care is based on best practice.

Only nurses who have achieved the competences set by the NMC for a registered advanced nurse practitioner will be permitted to call themselves by this title. The title will be protected through a registrable qualification in the Council's register.'

The NMC competences are mapped against the Knowledge and Skills Framework (KSF) and can be found on the enclosed CD.

2**Learning methods**

The case management competences framework is based on the principle that, wherever possible, learning should take place in the workplace. Learning in the workplace as opposed to the classroom means that people are more likely to relate their learning to their everyday work. This in turn means that learning is more likely to affect working practices and, therefore, to have a positive impact on standards.

For employers, workplace-based learning represents a considerable commitment. They must be prepared to facilitate, supervise and assess learning, allocate protected learning time and provide opportunities for coaching, mentoring and interprofessional learning. Practitioners will also need access to learning resources such as books, specialist equipment and electronic journals.

Effective work-based learning:

- relates directly to the learner's performance at work
- focuses on complex work-based tasks
- gives learners responsibility for their own learning
- strengthens teams by tackling problems that call for people with different roles and expertise to work together
- focuses on enhancing performance and upgrading experience
- focuses on innovative techniques and approaches to care.

You can find more evidence about workplace-based learning from the Sheffield Hallam University pilot on the enclosed CD.

3**Recognising prior learning**

The recognition of prior learning is important for two reasons. First, it recognises the importance of the tacit knowledge that experienced practitioners already possess, allowing them to demonstrate some or all of the competences in the framework. Second, it allows practitioners to take their learning with them when they move job.

Self-assessment can support the accreditation of prior learning by enabling practitioners to identify their own skills gaps, so that they can then focus their learning on their areas of weakness. For more information about self-assessment, see the Sheffield Hallam University case study on the enclosed CD.

4**Interprofessional learning**

The competences in the framework are drawn from Skills for Health and Skills for Care and are non-discipline-specific. They therefore support and promote interprofessional learning and the integration of health and social care, helping to develop a mature, flexible workforce.

Evidence suggests that interprofessional education is an effective way of encouraging collaboration in health and social care in order to improve services, bring about change and implement workforce strategies. See the following publications for more information:

- Barr H (2002) *Interprofessional education today, yesterday and tomorrow*. London, LTSN for Health Sciences and Practice.
- Flanagan J, Baldwin S and Clarke D (2000) 'Work-based learning as a means of developing and assessing nursing competence'. *Journal of Clinical Nursing* 9, 360-368.

5

Mentorship and coaching

Mentors have a key role to play in ensuring the success of workplace-based learning. Effective mentoring should give the **community matron/case manager**:

- an improved understanding of work issues, and exposure to different approaches to dealing with them.
- a sounding board for ideas
- access to the knowledge of someone in a similar role about the external environment and the characteristics and culture of the sector.
- opportunities for self-learning.
- a chance to focus on priorities.
- an increase in confidence.

Leadership and race equality: mentoring guidelines (NHS Leadership Centre, 2004), p.2

As well as encouraging self-efficacy and personal authority, mentors may act as coaches, supporting the development of the competences set out in the case management competences framework. The framework is set out in full on the enclosed CD.

Matrix mentorship and coaching

Community matrons and **case managers** will need access to two types of mentorship/coaching: a key mentor, who will provide support over an extended period as they develop into the role; and a matrix of mentors/coaches who can help them develop specific skills. Part of the key mentor's role will involve supporting the identification of the right coach at the right time.

For example, a **community matron** who wishes to update his/her skills and knowledge in Chronic Obstructive Pulmonary Disease (COPD) may benefit from the opportunity to shadow staff in a chest clinic and to work on their auscultation skills with a physiotherapist. The key mentor's role will then be to challenge and support as the practitioner applies their new learning.

Choosing a mentor or coach

Mentors and coaches should have sophisticated interpersonal skills, and a broad overview of the knowledge and skills **community matrons** and **case managers** need. They should also be supportive, enabling and committed to the mentoring relationship.

Organisations will need to look at ways of preparing expert practitioners to become effective mentors and coaches. They will also need to assure the quality of mentors and coaches using clinical governance frameworks.

Details of the Sheffield Hallam University mentoring pilot can be found on the enclosed CD.

6

Organisational governance

Employers must ensure that their staff are equipped to do their jobs effectively, by using a clinical governance framework. Organisations that offer work-based learning will need to provide sufficient access to appropriate learning opportunities, and protected learning and reflection time. They will also need to provide competent mentorship and ongoing continuing professional development (CPD) commensurate with the level of the role.

In return, employees and practitioners must work to the standards and competences required by the registering body and the role. Practitioners must work within their scope of practice and the relevant legislation. **Community matrons** will need to continue to develop their practice in line with the standards the NMC has set for advanced practitioners.

7

Collaborative commissioning

Because the number of **community matrons** will be relatively low compared with other roles, education provision will be low in volume. Education commissioners should consider commissioning programmes that are based on collaboration between HEIs. This will be the most effective way of achieving flexible, responsive provision at local level.

In the past, there have often been lengthy delays between the identification of education requirements and the provision of learning programmes. Current reconfiguration plans mean that education planning and provision must be led not only by local planning and provision, but also by local need. If commissioning is to reflect local delivery and service improvement plans, provision must be flexible and timely in order to meet the needs of a rapidly adapting workforce.

See the enclosed CD for case studies that demonstrate how health organisations are using collaborative commissioning.

8

Assessment of competences

As with all staff, employers will need to ensure through their Human Resource policies and clinical governance arrangements that both **community matrons** and **case managers** are competent to fulfil the functions of their roles. Practitioners are also responsible for ensuring that they are competent to undertake their role.

Further guidance on the assessment of **community matrons** and **case managers** in the workplace will be provided in the summer of 2006.

9

Clinical Supervision and continuing professional development

All practitioners should be given opportunities for continuing professional development (CPD). Ongoing clinical supervision, mentoring and reflective practice are essential if **community matrons** and **case managers** are to maintain their competence (and, in the case of **community matrons**, their advanced practitioner status). CPD should be flexible, local and based around the competences needed for the practitioner's role.

10

Supporting experienced hospital nurses to move into community matron roles

Practitioners who make the transition from working within a single institution to working in the community will need additional support from their employers to cope with the significant differences between working in hospital and working in the community. These include:

- Patients in the community are in control of all decisions affecting their health and wellbeing. To provide effective care, **community matrons** and **case managers** will need to develop strong personal relationships with their patients
- 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.

Employers will need to provide specific support for learning. They will also need to ensure stakeholder buy-in both from within the organisation and the wider health and social care sector.

This information is taken from Drennan V, Goodman C, Leyshon S and Peacock R (2005) Supporting experienced hospital nurses to move into **community matron** roles. London, The Primary Care Nursing Research Unit. An executive summary of the report (including a checklist for employers) is provided on the enclosed CD.

Next steps: putting the education framework into practice

For employers:

- use the case management competences framework to recruit **community matrons/case managers**
- use the case management competences framework to analyse the learning needs of each **community matron/case manager**
- use the learning needs analysis to develop a personalised learning plan, and to inform workforce development and succession planning
- use the learning needs analysis and the education principles to decide how you will meet the practitioner's learning needs. Is your organisation equipped to support and deliver the appropriate training and education?
- use learning needs analysis, the case management competences framework and the education framework to commission education and training from HEIs
- use the case management competences framework and the education framework to develop a shared understanding of workforce requirements with partner HEIs
- use the case management competences framework and the education framework to monitor performance.

For HEIs:

- use the case management competences framework and the education framework to develop a shared understanding of workforce requirements with partner health and social care organisations
- use the case management competences framework and the education framework to help you understand the workforce needs of employers and students
- use the underlying principles in the education framework and the indicative learning content in the case management competences framework to design programmes and modules
- collaborate with other HEIs to develop processes for recognising and accrediting prior learning
- use the underlying principles to help employers support learning in the workplace, for example by providing access to distance learning materials or supporting the development of mentors
- use the indicative learning content in the case management competences framework to review the learning needs of students on other programmes who either work with or would like to become **community matrons**
- use the case management competences to inform the development of any new courses.

Acknowledgments

The education framework

The following people have contributed to the development of this document:

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The case management competences framework

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