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Belinda Wigmore, Community Matron
Croydon Health Services UK

Sylvie Marshall-Lucette
Senior lecturer
St George’s University of London UK
Patients’ reactions to being selected by a computerised predictive risk tool for case management by a Community Matron in the UK
Introduction

• 15 million people in UK live with one or more long term condition

• 70% of the cost of the health and social care budget: £12.2 billion in 2011 (The Health and Social Care Information Centre 2013)

• Figures continue to rise!
Croydon
Level 3: Case management – identification of very high intensity users of unplanned secondary care.

Level 2: Disease-specific care management – specialist services to people with complex single need or multiple conditions.

Level 1: Supported self care – collaborative help to individuals and their carers.
Case management

• Introduction of local case management

• Establishing the role of Community Matron

• Specifically designed Combined Predictive Model

• New concept: Virtual Wards Framework
Examining the literature

- No direct reference within the literature
- Lateral thinking approach to searching
- Screening research most useful.....
Aim & Objectives

- To explore the reactions of patients who have been selected by a ‘computerised’ predictive risk tool for case management assessment.
- To elicit the selected patients’ views of being invited for a health assessment and case management by a community matron.
- To establish the impact of being selected for case management assessment on patients.
- To compare the patients’ experiences, between being selected for a service and being referred to a service, within a healthcare context.
Design & Methods

• Qualitative research approach: Phenomenology
• Sampling: Purposive
• Data collection: In-depth open ended interviews
• Interpretative Phenomenology Analysis (IPA)
• Ethical consideration: Full approval sought and granted
<table>
<thead>
<tr>
<th>Age/Gender</th>
<th>Ethnic origin</th>
<th>Social characteristics</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>63/ Male</td>
<td>White Irish</td>
<td>Owned building firm, lived in own home with wife, dog &amp; grown up children</td>
<td>Ischemic Heart disease, (IHD)diabetes, ulcerative colitis</td>
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<tr>
<td>75/ Female</td>
<td>White British</td>
<td>Widowed lived alone in rented accommodation with her dog</td>
<td>Recurrent pylo-nephritis</td>
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<tr>
<td>81/ Male</td>
<td>White British</td>
<td>Widower, lived alone in own home. Previous experience in armed forces</td>
<td>Heart failure, renal failure, atrial fibrillation</td>
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<tr>
<td>80/Female</td>
<td>White British</td>
<td>Lived in rented accommodation with husband and dog</td>
<td>COPD, type 2 diabetes, thrombocytopenia, cor-pulmonale</td>
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<tr>
<td>78/ Female</td>
<td>Indian origin</td>
<td>Widowed, shared own house with son. Retired teacher</td>
<td>Diabetes, strokes, IHD hypothyroidism,</td>
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<tr>
<td>79/ Female</td>
<td>White British</td>
<td>Widowed, lived alone in own home</td>
<td>Polymyalgia, atrial fibrillation, cervical spondylitis</td>
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<tr>
<td>87/Female</td>
<td>White British</td>
<td>Widowed, lived alone in own home. Retired teacher</td>
<td>Breast cancer, heart failure</td>
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<tr>
<td>82/ Female</td>
<td>West Indian</td>
<td>Lived with her husband</td>
<td>Renal failure, IHD heart failure</td>
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<tr>
<td>Themes</td>
<td>Sub Themes</td>
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<td>Dynamic perception of ill-health</td>
<td>➢ Relentlessness of ill health</td>
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<td></td>
<td>➢ Burden of ill health</td>
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<td>➢ Knowing own ill-health</td>
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<td></td>
<td>➢ Battlefield of ill health</td>
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<td>Dimensions of health guidance</td>
<td>➢ Imposed guidance</td>
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<td></td>
<td>➢ Self directed guidance</td>
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<td></td>
<td>➢ Paternal Guidance</td>
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<td>Dimensions of trust</td>
<td>➢ “Doing things thoroughly”</td>
<td></td>
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<td></td>
<td>➢ Trusting own experience</td>
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<td>➢ Trusted professional/other</td>
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<td>➢ Loss of trust</td>
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<td>Surveillance of health</td>
<td>➢ Expectation and acceptance surveillance</td>
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<td>➢ Health details as public property</td>
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<td></td>
<td>➢ Pleased to be chosen</td>
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Patients’ Reactions to Computerised Referrals

Conceptual framework

Dimensions of trust (within health care)
- "doing things thoroughly"
- Trusting own experience
- Trusted professional/other
- Loss of trust

Dimensions of guidance (in health)
- Imposed
- Self directed
- Paternal

Dynamic perception of ill-health
- Knowing own health
- Burden of ill health
- Battlefield of ill health
- Relentlessness of ill health

Surveillance of health
- Expectation and acceptance (of surveillance)
- Pleased to be chosen
- Health details as public property

Positively engaged with health care

Negatively engaged with health care
Conclusions

• Risk tools will be more widely used to target health care
• Hard to reach individuals required to engage in pro-active case management to prevent the rising cost of chronic ill health
• Further research: specifically targeting those who have refused case management and yet could potentially benefit from it the most.
Contact details

Belinda Wigmore  
Community Matron  
Croydon Health services

Belinda.wigmore@croydonhealth.nhs.uk

Dr Sylvie Marshall-Lucette  
Senior Lecturer, FHSCS  
Kingston University & St George’s University of London

S.Marshall-Lucette@sgul.kingston.ac.uk