

Appendices.

Appendix 1: Consent forms

Consent form for carers.

Title of research study: An Investigation of Integrated Working in a Chronic Conditions Management Service in X
Name of Researcher: Ben Duxbury

Please initial box:

1. I confirm that I have read and understood the information sheet dated... for the above study. I have had the opportunity to consider the information, ask questions, and have had 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, without any medical care or legal rights being affected ☐
3. I understand that all reports related to my participation in this study will be fully anonymised and that all interview recordings will be stored securely, only seen by the researchers and will be destroyed ten years after the research is completed and published ☐
4. I agree to take part in the above study ☐

_____	_____	_____
Name of carer	Date	Signature

_____	_____	_____
Name of researcher	Date	Signature

When completed, one copy is retained by the carer and one copy is for the researcher

Consent form for clients.

Title of research study: An investigation of integrated working in a Chronic
Conditions Management Service in X
Name of Researcher: Ben Duxbury

Please initial box:

1. I confirm that I have read and understood the information sheet dated.. for the above study. I have had the opportunity to consider the information, ask questions, and have had 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, without my medical care or legal rights being affected
3. I understand that all reports related to my participation in this study will be fully anonymised and that all interview recordings will be stored securely, only seen by the researchers and will be destroyed ten years after the research is completed and published
4. I agree to take part in the above study

_____	_____	_____
Name of client	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature

When completed, one copy to be retained by the client and one copy for the researcher

Consent form for practitioners.

Title of research study: An Investigation of Integrated Working in a Chronic Conditions Management Service in X

Name of Researcher: Ben Duxbury

Please initial box:

1. I confirm that I have read and understood the information sheet dated...for the above study. I have had the opportunity to consider the information, ask questions, and have had 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, without legal rights being affected ☐
3. I understand that all reports related to my participation in this study will be fully anonymised and that all audio recordings will be stored securely, only seen by the researchers and will be destroyed ten years after the research is completed and published ☐
4. I agree to take part in the above study ☐

_____	_____	_____
Name of practitioner	Date	Signature

_____	_____	_____
Name of researcher	Date	Signature

When completed one copy retained by the practitioner and one copy for the researcher

Consent form for referrers.

Title of research study: An Investigation of Integrated Working in a Chronic Conditions Management Service in X

Name of Researcher: Ben Duxbury

Please initial box:

1. I confirm that I have read and understood the information sheet dated...for the above study. I have had the opportunity to consider the information, ask questions, and have had 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, without legal rights being affected
3. I understand that all reports related to my participation in this study will be fully anonymised and that all audio recordings will be stored securely, only seen by the researchers and will be destroyed ten years after the research is completed and published
4. I agree to take part in the above study

_____	_____	_____
Name of referrer	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature

When completed one copy retained by the referrer and one copy for the researcher

Consent form for representatives from lead agencies.

Title of research study: An Investigation of Integrated Working in a Chronic
Conditions Management Service in X
Name of Researcher: Ben Duxbury

Please initial box:

1. I confirm that I have read and understood the information sheet dated....for the above study. I have had the opportunity to consider the information, ask questions, and have had 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, without legal rights being affected
3. I understand that all reports related to my participation in this study will be fully anonymised and that all audio recordings will be stored securely, only seen by the researchers and will be destroyed ten years after the research is completed and published
4. I agree to take part in the above study

_____	_____	_____
Name of representative	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature

When completed one copy retained by the representative and one copy for the researcher

Appendix 2: Cover letters

Carers

Dear Sir/Madam,

I am a PhD student and a qualified nurse at the College of Human and Health Sciences, Swansea University. My reason for writing to you is to invite you to participate in a research study that I am undertaking. The title of this research is:

An Investigation of Integrated Working in a Chronic Conditions Management Service in X.

I am carrying out the research to explore the processes involved in integrated or joined-up working in the provision of care for people living with chronic conditions in X. As part of the project I will be interviewing people living with chronic conditions and their carers. I am writing to you as I understand that you are living with a chronic condition. I am inviting you to take part in a face to face interview with myself, which will last about one hour. At the interview you will be asked about your views on the care provided by the Community Resource Team. With your permission the interview will take place at your home or at a venue which is convenient for you. Any travel expenses will be reimbursed.

I have provided an information sheet that sets out in greater detail what this study involves. Please take time to read this carefully, and discuss it with other people if you would like to. If you decide to participate, please complete the attached reply slip and return it in the enclosed FREEPOST envelope (no stamp required). I will then contact you to make arrangements for conducting the interview.

If you have any questions or require further information regarding this study please do not hesitate to contact me on Tel No: 0776 705 6780 or email: 442741@swansea.ac.uk

Yours sincerely,

Ben Duxbury

Clients

Dear Sir/Madam,

I am a PhD student and a qualified nurse at the College of Human and Health Sciences, Swansea University. My reason for writing to you is to invite you to participate in a research study that I am undertaking. The title of this research is:

An Investigation of Integrated Working in a Chronic Conditions Management Service in X.

I am carrying out the research to explore the processes involved in integrated or joined-up working in the provision of care for people living with chronic conditions in X. As part of the project I will be interviewing people living with chronic conditions and their carers. I am writing to you as I understand that you are a carer of someone who is living with a chronic condition. I am inviting you to take part in a face to face interview with myself, which will last about one hour. At the interview you will be asked about your views on the care provided by the Community Resource Team. With your permission the interview will take place at your home or at a venue which is convenient for you. Any travel expenses will be reimbursed.

I have provided an information sheet that sets out in greater detail what this study involves. Please take time to read this carefully, and discuss it with other people if you would like to. If you decide to participate, please complete the attached reply slip and return it in the enclosed FREEPOST envelope (no stamp required). I will then contact you to make arrangements for conducting the interview.

If you have any questions or require further information regarding this study please do not hesitate to contact me on Tel No: 01792 518 568 or email: 442741@swansea.ac.uk

Yours sincerely,

Ben Duxbury

Front-line practitioners

Dear Sir/Madam

I am a PhD student and a qualified nurse at the School of Health Science, Swansea University. My reason for writing to you is to invite you to participate in a research study that I am undertaking. The title of this research is:

An Investigation of Integrated Working in a Chronic Conditions Management Service in X.

I am carrying out the research to explore the processes involved in integrated working in the provision of care for people living with chronic conditions. As part of the project I will be interviewing members of the Chronic Conditions Management (CCM) Service in four separate focus group discussions, with approximately six practitioners in each discussion group. The discussion groups will explore your views on the provision of care to people living with chronic conditions, and particularly on the factors that enhance or impede integrated working. If you decide to take part in this study it will involve approximately two hours of your time including time for refreshments, which will be provided. The discussion groups will take place at the CCM centre or at a venue that is convenient to you. Any travel expenses will be reimbursed.

I have enclosed an information sheet that sets out in greater detail what this study involves. Please take time to read this carefully, and discuss it with other people if you would like to. If you are interested in participating then, please complete the attached reply slip and return in the enclosed FREEPOST envelope (no stamp required). I will then contact you to make arrangements for conducting the focus group discussion.

If you have any questions or require further information regarding this study please do not hesitate to contact me on Tel No: 01792 518 568 or email: 442741@swansea.ac.uk

Yours sincerely,

Ben Duxbury

Representatives from lead agencies

Dear Sir/Madam

I am a PhD student and a qualified nurse at the School of Health Science, Swansea University. My reason for writing to you is to invite you to participate in a research study that I am undertaking. The title of this research is:

An Investigation of Integrated Working in a Chronic Conditions Management (CCM) Service in X.

I am carrying out the research to explore the processes involved in integrated or joined-up working in the provision of care for people living with chronic conditions in X. As part of the project I will be interviewing six representatives from the lead agencies that work with the CCM Service. I am inviting you to take part in a face to face interview with myself, which will last about one hour. At the interview you will be asked about your views on the processes of the provision of integrated care by the CCM Service. The interview will take place at a location that is convenient for you. Any travel expenses will be reimbursed.

I have provided an information sheet that sets out in greater detail what this study involves. Please take time to read this carefully, and discuss it with other people if you would like to. If you decide to participate, please complete the attached reply slip and return it in the enclosed FREEPOST envelope (no stamp required). I will then contact you to make arrangements for conducting the interview.

If you have any questions or require further information regarding this study please do not hesitate to contact me on Tel No: 01792 518 568 or email: 442741@swansea.ac.uk

Yours sincerely,

Ben Duxbury

Referrers

Dear Sir/Madam,

I am a PhD student and a qualified nurse at the School of Health Science, Swansea University. My reason for writing to you is to invite you to participate in a research study that I am undertaking. The title of this research is:

An Investigation of Integrated Working in a Chronic Conditions Management Service in X.

I am carrying out the research to explore the processes involved in integrated working in the provision of care for people living with one or more chronic conditions in X. As part of the project I will be conducting telephone interviews with six referrers to the Chronic Conditions Management Service in X. If you decide to take part in this study we will need approximately forty minutes to discuss your views on the care of people living with chronic conditions and the factors that impede or enhance integrated working in this area.

I have provided an information sheet that sets out in greater detail what this study involves. Please take time to read this carefully, and discuss it with other people if you would like to. If you decide to participate, please complete the attached reply slip and return in the enclosed FREEPOST envelope (no stamp required). If you have any queries regarding this study, or you need to discuss arrangements, do not hesitate to contact me on Tel: 01792 518 568 or by email: 442741@swansea.ac.uk

Yours faithfully,

Ben Duxbury

Appendix 3: Participant information sheets

Carers

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it involves. Please take time to read the following information carefully and discuss it with others if you wish.

Study title: An Investigation of Integrated working in a Chronic Conditions Management Service in X

What is the purpose of the study?

I aim to explore the processes involved in integrated or joined-up working in the Chronic Conditions Management Service in X and the impact on the care of people living with chronic conditions and their carers.

Why have I been invited?

I would like to speak to carers of people who have one or more chronic conditions who have been referred to the Chronic Conditions Management Service in X. Nine other carers will also be invited to participate.

Do I have to take part?

Taking part in the research is entirely voluntary. It is up to you to decide when you have read the information sheet. If you agree to take part I will ask you to sign a consent form. You are free to withdraw at any time without giving a reason. The care services of the person you look after will not be affected whether you agree to take part or not.

What will happen to me if I take part?

If you consent to take part you will be contacted by the researcher to arrange a suitable date, time and place for an interview. With your permission the interview will take place at your home or at another location that is convenient to you. The interview will last for approximately one hour and with your permission will be tape-recorded. The interview will focus on the care that is delivered to people 389 using the Chronic Conditions Management Service and particularly on the factors which help or hinder joined-up working. Any travel expenses will be reimbursed.

What are the benefits of the research to the participants?

There are no immediate benefits for you, although having the opportunity to discuss and relate some of your experiences and concerns may be of some benefit. However, it is expected that the information gained from this study will inform policy and practice with regard to the development of joined-up working in Chronic Conditions Management services in the future.

Will there be any harm to participants?

Whilst it is not anticipated that you would be distressed through participating in this study, if this did occur then the researcher would discontinue the data collection and

seek to provide support. The researcher will have contact details of sources of support, such as local GPs, which will be offered to anyone who may become distressed. The researcher conducting the interview is a qualified nurse bound by the Nursing and Midwifery Code of Conduct (2008).

What about confidentiality?

The researcher has ethical and professional responsibilities to keep all information confidential. This means that your name will not appear in any reports arising from this project. All interview recordings and the typed notes from the interviews will be stored securely, only seen by the researcher and will be destroyed ten years after the research is completed and published. However, as the researcher is bound by the Nursing and Midwifery Code of Conduct (2008), reports of unsafe/unprofessional practice cannot be kept confidential.

Has the study been reviewed and approved?

The study has been reviewed and approved by the Research Ethics Committee of Dyfed Powys.

What happens with the results of this study?

When the study has been completed a report will be sent to the funding body, The Welsh Assembly Government to contribute to policy and practice 390 development in Wales and elsewhere. You will be invited to attend a presentation of the findings of the report at a local meeting; the findings will also be presented to the X Chronic Conditions Management Service and the Local Authority. The findings will also be presented at conferences related to Chronic Conditions Management Service and published in social care and health journals.

Thank you for considering this information. If you decide to take part in this study, I would be grateful if you could return the attached reply slip by.....using the enclosed FREEPOST envelope (no stamp required).

If you have any further questions, please contact Ben Duxbury at: School of Health Science, Swansea University, Swansea SA2 8PP, Tel: 01792 518 568
Email: 442741 swansea.ac.uk

If you have any general enquiries or concerns about the conduct of this research, please contact: Dr. Ian Pepper, Research Manager, Institute for Health Research, Swansea University, Swansea SA2 8PP, Tel: 01792 518 539
Email: i.pepper@swansea.ac.uk

Reply Slip

**Study Title: An Investigation of Integrated Working in
a Chronic Conditions Management Service in X**

**I (print name) am interested in
participating in the above named study and give permission for the researcher
to contact me.**

Signature: _____

Date: _____

**Please return your reply slip, using the enclosed FREEPOST envelope (no
stamp required).**

Thank you for your time and cooperation

Ben Duxbury

School of Health Science

Swansea University

Swansea, SA2 8PP

Clients

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it involves. Please take time to read the following information carefully and discuss it with others if you wish.

Study title: An Investigation of Integrated working in a Chronic Conditions Management Service in X

What is the purpose of the study?

I aim to explore the processes involved in integrated or joined-up working in the Chronic Conditions Management Service in X and the impact on the care of people living with chronic conditions and their carers.

Why have I been invited?

I would like to speak to people living with one or more chronic conditions who have received care from the Chronic Conditions Management service. A total of twenty clients will be invited to participate.

Do I have to take part?

Taking part in the research is entirely voluntary. It is up to you to decide when you have read the information sheet. You are free to withdraw at any time without giving a reason. Your care will not be affected whether you agree to take part or not.

What will happen to me if I take part?

If you consent to take part you will be contacted by the researcher to arrange a suitable date, time and place for an interview. With your permission the interview will be conducted at your home or at another location that is convenient for you. The interview will last for approximately one hour and with your permission will be tape-recorded. The interview will focus on your views of the care that you received from the Chronic Conditions Management Service and particularly on the 393 factors which help or hinder joined-up working between health and social care practitioners. Any travel expenses will be reimbursed.

What are the benefits of the research to the participants?

There are no immediate benefits for you, although having the opportunity to discuss and relate some of your experiences and concerns may be of some benefit. However, it is expected that the information gained from this study will inform policy and practice with regard to the development of joined-up working in Chronic Conditions Management services in the future.

Will there be any harm to participants?

Whilst it is not anticipated that you would be distressed through participating in this study, if this did occur then the researcher would discontinue the data collection and seek to provide support. The researcher will have contact details of sources of support, such as local GPs, which will be offered to anyone who may become distressed. The researcher conducting the interview is a qualified nurse bound by

the Nursing and Midwifery Code of Conduct (2008).

What about confidentiality?

The researcher has ethical and professional responsibilities to keep all information confidential. This means that your name will not appear in any reports arising from this project. All interview recordings and the typed notes from the interviews will be stored securely, only seen by the researcher and will be destroyed ten years after the research is completed and published. However, as the researcher is bound by the Nursing and Midwifery Code of Conduct (2008), reports of unsafe/unprofessional practice cannot be kept confidential.

Has the study been reviewed and approved?

The study has been reviewed and approved by the Research Ethics Committee of Dyfed Powys.

What happens with the results of this study?

When the study has been completed a report will be sent to the funding body, The Welsh Assembly Government to contribute to policy and practice 394 development in Wales and elsewhere. You will be invited to attend a presentation of the findings of the report at a local meeting; the findings will also be presented to the X Chronic Conditions Management Service and the Local Authority. The findings will also be presented at conferences related to Chronic Conditions Management and published in social care and health journals.

Thank you for considering this information. If you decide to take part in this study, I would be grateful if you could return the attached reply slip by..... using the enclosed FREEPOST envelope (no stamp required).

If you have any further questions, please contact Ben Duxbury at: School of Health Science, Swansea University, Swansea SA2 8PP, Tel: 01792 518 568
Email: 442741@swansea.ac.uk

If you have any general enquiries or concerns about the conduct of this research, please contact: Dr. Ian Pepper, Research Manager, Institute for Health Research, Swansea University, Swansea SA2 8PP, Tel: 01792 518 539
Email: i.pepper@swansea.ac.uk

Reply Slip

**Study Title: An Investigation of Integrated Working in
a Chronic Conditions Management Service in X**

**I (print name) am interested in
participating in the above named study and give permission for the researcher
to contact me.**

Signature: _____

Date: _____

395

**Please return your reply slip in the enclosed FREEPOST envelope (no stamp
required).**

Thank you for your time and cooperation

**Ben Duxbury
School of Health Science
Swansea University
Swansea, SA2 8PP
Tel: 01792 518 568**

Health and social care practitioners

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it involves. Please take time to read the following information carefully and discuss it with others if you wish.

Study title: An Investigation of Integrated Working in a Chronic Conditions Management Service in X

What is the purpose of the study?

I aim to explore the processes involved in integrated or joined-up working in the Chronic Conditions Management (CCM) Service in X and the impact on the care of people living with chronic conditions and their carers.

Why have I been invited?

You have been invited to take part because of your role as a member of the CCM Service. A total of 24 practitioners have been invited to participate.

Do I have to take part?

Taking part in the research is entirely voluntary. It is up to you to decide when you have read the information sheet. If you agree to take part I will ask you to sign a consent form. You are free to withdraw at any time without giving a reason.

What will happen to me if I take part?

If you consent to take part you will be contacted by the researcher to arrange a date and venue for a focus group discussion. This will involve no more than five other practitioners and will be conducted, with your permission, either at the CCM centre or at a venue that is convenient for you. The discussion will last for approximately two hours (which includes time for refreshments, briefing and debriefing) and will, with the group's permission, be tape-recorded. Ground rules regarding confidentiality will be clearly stated prior to each meeting and sufficient time for debriefing will be included. The discussion will focus on the care that 397 is delivered to people using the CCM Service and particularly on the factors which enhance or impede integrated working. Any travel expenses will be reimbursed.

What are the benefits of the research to the participants?

There are no immediate benefits for you, although having the opportunity to discuss and relate some of your experiences and concerns may be of some benefit. However, it is expected that the information gained from this study will inform policy and practice with regard to the development of integrated working in CCM services in the future.

Will there be any harm to participants?

Whilst it is not anticipated that you would be distressed through participating in this study, if this did occur then the researcher would discontinue the data collection and seek to provide support. The researcher will have contact details of sources of support, such as local GPs, which will be offered to anyone who may become

distressed. The researcher conducting the interview is a qualified nurse bound by the Nursing and Midwifery Code of Conduct (2008).

What about confidentiality?

The researcher has ethical and professional responsibilities to keep all information confidential. This means that data will be presented as an aggregate and any reports of this project will be made anonymous; this will prevent identification of any of the participants. All recordings and transcripts will be stored securely, only seen by the researcher and will be destroyed ten years after the research is completed and published. However, as the researcher is bound by the Nursing and Midwifery Code of Conduct (2008), reports of unsafe/unprofessional practice cannot be kept confidential.

Has the study been reviewed and approved?

The study has been reviewed and approved by the Research Ethics Committee of Dyfed Powys.

What happens with the results of this study?

When the study has been completed a report will be sent to the funding body, The Welsh Assembly Government. You will be invited to attend a presentation of the findings of the report at a local meeting; the findings will also be presented to the X CCM Service and the Local Authority. The findings will also be presented at conferences related to CCM and published in social care and health journals.

Thank you for considering this information. If you decide to take part in this study, I would be grateful if you could return the attached reply slip by..... using the enclosed FREEPOST envelope (no stamp required).

If you have any further questions, please contact Ben Duxbury at: School of Health Science, Swansea University, Swansea SA2 8PP, Tel: 01792 518 568
Email: 442741@swansea.ac.uk

If you have any general enquiries or concerns about the conduct of this research, please contact: Dr. Ian Pepper, Research Manager, Institute for Health Research, Swansea University, Swansea SA2 8PP, Tel: 01792 518 539
Email: i.pepper@swansea.ac.uk

Reply slip

**Study Title: An Investigation of Integrated Working in
a Chronic Conditions Management Service in X**

**I (print name) am interested in
participating in the above named study and give permission for the researcher
to contact me.**

Signature: _____

Date: _____

**Please return your reply slip in the enclosed FREEPOST envelope (no stamp
required).**

Thank you for your time and cooperation

**Ben Duxbury
School of Health Science
Swansea University
Swansea, SA2 8PP
Tel: 01792 518 568**

Referrers

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it involves. Please take time to read the following information carefully and discuss it with others if you wish.

Study title: An Investigation of Integrated Working in a Chronic Conditions Management Service in X

What is the purpose of the study?

I aim to explore the processes involved in integrated working in the Chronic Conditions Management (CCM) Service in X and the impact on the care of people living with chronic conditions and their carers.

Why have I been invited?

You have been invited to take part because of your role as a referrer to the X CCM Service.

Do I have to take part?

Taking part in the research is entirely voluntary. It is up to you to decide when you have read the information sheet. If you agree to take part I will ask you to sign a consent form. You are free to withdraw at any time without giving a reason.

What will happen to me if I take part?

If you consent to take part you will be contacted by the researcher to arrange a date and time for a one-to-one telephone interview. The interview will last for approximately forty minutes and will, with your permission, be tape-recorded. The interview will focus on the care that is delivered to people using the CCM Service and particularly on the factors which enhance or impede integrated working.

What are the benefits of the research to the participants?

There are no immediate benefits for you, although having the opportunity to discuss and relate some of your experiences and concerns may be of some benefit.

401 However, it is expected that the information gained from this study will inform policy and practice with regard to the development of integrated working in CCM services in the future.

Will there be any harm to participants?

Whilst it is not anticipated that you would be distressed through participating in this study, if this did occur then the researcher would discontinue the data collection and seek to provide support.

The researcher will have contact details of sources of support, such as local GPs, which will be offered to anyone who may become distressed. The researcher conducting the interview is a qualified nurse bound by the Nursing and Midwifery Code of Conduct (2008).

What about confidentiality?

The researcher has ethical and professional responsibilities to keep all information confidential. This means that data will be presented as an aggregate and any reports of this project will be made anonymous; this will prevent identification of any of the participants. All recordings and transcripts will be stored securely, only seen by the researcher and will be destroyed ten years after the research is completed and published. However, as the researcher is bound by the Nursing and Midwifery Code of Conduct (2008), reports of unsafe/unprofessional practice cannot be kept confidential.

Has the study been reviewed and approved?

The study has been reviewed and approved by the Research Ethics Committee of Dyfed Powys.

What happens with the results of this study?

When the study has been completed a report will be sent to the funding body, The Welsh Assembly Government. You will be invited to attend a presentation of the findings of the report at a local meeting; the findings will also be presented to the X CCM Service and the Local Authority. The findings will also be presented at conferences related to CCM and published in social care and health journals. 402

Thank you for considering this information. If you decide to take part in this study, I would be grateful if you could return the attached reply slip by..... using the enclosed FREEPOST envelope (no stamp required).

If you have any further questions, please contact Ben Duxbury at: School of Health Science, Swansea University, Swansea SA2 8PP, Tel: 01792 518 568
Email: 442741@swansea.ac.uk

If you have any general enquiries or concerns about the conduct of this research, please contact: Dr. Ian Pepper, Research Manager, Institute for Health Research, Swansea University, Swansea SA2 8PP, Tel: 01792 518 539
Email: i.pepper@swansea.ac.uk

Reply slip

**Study Title: An Investigation of Integrated Working in
a Chronic Conditions Management Service in X**

**I (print name) am interested in
participating in the above named study and give permission for the researcher
to contact me.**

Signature: _____

Date: _____

**Please return your reply slip in the enclosed FREEPOST envelope (no stamp
required).**

Thank you for your time and cooperation

**Ben Duxbury
School of Health Science
Swansea University
Swansea, SA2 8PP
Tel: 01792 518 568**

Lead agency representatives

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it involves. Please take time to read the following information carefully and discuss it with others if you wish.

Study title: An Investigation of Integrated Working in a Chronic Conditions Management Service in X

What is the purpose of the study?

I aim to explore the processes involved in integrated working in the Chronic Conditions Management (CCM) Service in X and the impact on the care of people living with chronic conditions and their carers.

Why have I been invited?

You have been invited to take part because of your role as a representative from a lead agency working in collaboration with the X CCM Service.

Do I have to take part?

Taking part in the research is entirely voluntary. It is up to you to decide when you have read the information sheet. If you agree to take part I will ask you to sign a consent form. You are free to withdraw at any time without giving a reason.

What will happen to me if I take part?

If you consent to take part you will be contacted by the researcher to arrange a date and venue for a one-to-one discussion at a location that is convenient to you. The discussion will last for approximately one hour and will, with your permission, be tape-recorded. The interview will focus on the care that is delivered to people using the CCM Service and particularly on the factors which enhance or impede integrated working. Any travel expenses will be reimbursed.

What are the benefits of the research to the participants?

There are no immediate benefits for you, although having the opportunity to discuss and relate some of your experiences and concerns may be of some benefit. However it is expected that the information gained from this study will inform policy and practice with regard to the development of integrated working in CCM services in the future.

Will there be any harm to participants?

Whilst it is not anticipated that you would be distressed through participating in this study, if this did occur then the researcher would discontinue the data collection and seek to provide support. The researcher will have contact details of sources of support, such as local GPs, which will be offered to anyone who may become distressed. The researcher conducting the interview is a qualified nurse bound by the Nursing and Midwifery Code of Conduct (2008).

What about confidentiality?

The researcher has ethical and professional responsibilities to keep all information confidential. This means that data will be presented as an aggregate and any reports of this project will be made anonymous; this will prevent identification of any of the participants. All recordings and transcripts will be stored securely, only seen by the researcher and will be destroyed ten years after the research is completed and published. However, as the researcher is bound by the Nursing and Midwifery Code of Conduct (2008), reports of unsafe/unprofessional practice cannot be kept confidential.

Has the study been reviewed and approved?

The study has been reviewed and approved by the Research Ethics Committee of Dyfed Powys.

What happens with the results of this study?

When the study has been completed a report will be sent to the funding body, The Welsh Assembly Government. You will be invited to attend a presentation of the findings of the report at a local meeting; the findings will also be presented to the X CCM Service and the Local Authority. The findings will also be presented at conferences related to CCM and published in social care and health journals.

Thank you for considering this information. If you decide to take part in this study, I would be grateful if you could return the attached reply slip by..... using the enclosed FREEPOST envelope (no stamp required).

If you have any further questions, please contact Ben Duxbury at: School of Health Science, Swansea University, Swansea SA2 8PP, Tel: 01792 518 568
Email: 442741@swansea.ac.uk

If you have any general enquiries or concerns about the conduct of this research, please contact: Dr. Ian Pepper, Research Manager, Institute for Health Research, Swansea University, Swansea SA2 8PP, Tel: 01792 518 539
Email: i.pepper@swansea.ac.uk

Reply slip

**Study Title: An Investigation of Integrated Working in
a Chronic Conditions Management Service in X**

**I (print name) am interested in
participating in the above named study and give permission for the researcher
to contact me.**

Signature: _____

Date: _____

**Please return your reply slip in the enclosed FREEPOST envelope (no stamp
required).**

Thank you for your time and cooperation

**Ben Duxbury
School of Health Science
Swansea University
Swansea, SA2 8PP
Tel: 01792 518 568**

Appendix 4: Ethical approval letter

Mr. Benjamin Duxbury
PhD student
Room 235, Institute for Health Research
School of Health Science
2nd Floor Vivian Tower
Swansea University
Singleton Park
Swansea SA2 8PP

5 October 2009

Dear Mr. Duxbury

Study Title: **An Investigation of Integrated Working in a Chronic
Conditions Management Service in X**
REC reference number: **09/WMW01/18**

Thank you for your letter of 28 September 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

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

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).

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.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) 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 the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.*

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:

<i>Document</i>	<i>Version</i>	<i>Date</i>
WORD funding letter	from Andy Privett	27 February 2009
Supervisor's CV	Dr Susan Philpin	29 July 2009
Participant Consent Form: Clients	1	27 July 2009
Participant Information Sheet: Clients	1	27 July 2009
Letter of invitation to participant	1	27 July 2009
Interview Schedules/Topic Guides	1	28 July 2009
Compensation Arrangements		01 August 2009
Letter from Sponsor	signed by Mr Ceri Jones	18 May 2009
Covering Letter		
Protocol		30 July 2009
Investigator CV	signed by B.Duxberry	30 July 2009
REC application	2.2	03 August 2009
Covering Letter		28 September 2009
Participant Information Sheets	2	22 September 2009
Participant Consent Forms	2	22 September 2009
Contact/Reply Slips		
Response to Request for Further Information		

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

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

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.

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
- 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.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/WMW01/18	Please quote this number on all correspondence
--------------------	---

Yours sincerely

Dr X
Chair

Email: X

Enclosures: “After ethical review – guidance for researchers”

Copy to: Mr Ceri Jones
 R&D office

Appendix 5: Interview schedules

Interview schedule for informal carers

Prior to beginning the interview:

Introductions. Revisiting of information sheet. Explanation of purposes of research, publication details etc. of report. Your answers will not have a direct impact on care received (either positive or negative) but the feedback will provide (hopefully) help in the future for you/others as a result. I have names/numbers if you need to contact people for support/help. I am recording to facilitate my writing up, is that OK? Anything you say will be anonymised/aggregated so you will not be identifiable. Confidentiality issues. If there are any questions that you don't want to answer, that's fine. If you want to discontinue at any time, that's fine. Ask for written consent.

Date:

Time:

Place:

Name:

Date of birth:

Interview

Question: Could you tell me about the care received by the person you care for?

Question: Do you get any additional support for your own needs?

Question: How long has the person (receiving care) been receiving this care?

Question: How did he/she get referred to this service? Was this process easy?

Question: How did he/she find out about this service?

Question: Have you noticed any differences in the service since September?

- If yes – in what way?
- If no – explain the change that has happened

Question: Were you informed that the services were changing or asked your opinion about changes in the service?

- If yes, in what way?
- If no, would you like to have been asked a) about the existing services b) your opinion about possible changes/your own ideas for change

Question: Are you satisfied with the services he/she currently receives?

Question: Are you satisfied with the support you receive?

Question: Are there any shortfalls in the current service, i.e. are there any services that you are not getting currently that you think would help?

Question: If he/she didn't get current service, how would that impact on you?

Question: Are there any changes in the service that could be made that would benefit you?

Question: What is the impact of the support you receive and the services he/she receives on:

- Your health?
- Your life in general?
- Your independence?
- Your ability to live at home?

Question: What would the impact on you of:

- Less care services being provided?
- More care services being provided?

Question: Do you feel you and/or the person you care for make decisions jointly with the person/people who provide care?

- If yes – how? Can you give me an example?
- If no, would you like to be more involved in decision-making?

Question: To what extent do you think that the different people who provide care (if more than one) communicate with each other?

Question: Did you have to answer similar questions when you were first assessed by/first met the care provider?

Question: How easy/difficult is it to get hold of services if you need help?

Question: Have you experienced any problems/issues with the service?

Question: Is there anything else related to the services that you receive that you'd like to tell me about?

After ending the interview *Thank interviewee for participation; explain that there will be a dissemination event to which they will be invited. Check if everything is understood including consent. Would it be possible to come back to you in the future if anything is unclear on the recording? Any questions?*

Interview schedule for clients

Prior to beginning the interview:

Introductions. Revisiting of information sheet. Explanation of purposes of research, publication details etc. of report. Your answers will not have a direct impact on the care you receive (either positive or negative) but the feedback will provide (hopefully) help in the future for you/others as a result. I have names/numbers if you need to contact people for support/help. I am recording to facilitate my writing up, is that OK? Anything you say will be anonymised/aggregated so you will not be identifiable. Confidentiality issues. If there are any questions that you don't want to answer, that's fine. If you want to discontinue at any time, that's fine. Ask for written consent.

Date:

Time:

Place:

Name:

Date of birth:

Interview

Question: Could you tell me about the care you receive?

Question: How long have you been receiving this care?

Question: How did you get referred to this service? Was this process easy?

Question: How did you find out about this service?

Question: Have you noticed any differences in the service since September?

- If yes – in what way?
- If no – explain the change that has happened

Question: Were you informed that the services were changing or asked your opinion about changes in the service?

- If yes, in what way?
- If no, would you like to have been asked a) about the existing services b) your opinion about possible changes/your own ideas for change

Question: Are you satisfied with the services you currently receive?

Question: Are there any shortfalls in the current service, i.e. are there any services that you're not getting currently that you think would help you?

Question: If you didn't get the services that you're currently getting, how would that impact on you?

Question: Are there any changes in the service that could be made that would benefit you?

Question: What is the impact of the services you receive on:

- Your health?
- Your life in general?
- Your independence?
- Your ability to live at home?

Question: What would the impact on you be of:

- Less care services being provided?
- More care services being provided?

Question: Do you have someone who helps you, like a friend, relative or neighbour?

Question: Do you feel you and/or the informal carer make decisions jointly with the person/people who provide your care?

- If yes – how? Can you give me an example?
- If no, would you like to be more involved in decision-making?

Question: To what extent do you think that the different people who provide care (if more than one) communicate with each other?

Question: Did you have to answer similar questions when you were first assessed by/first met the care provider?

Question: How easy/difficult is it to get hold of services if you need to contact them?

Question: Have you experienced any problems/issues with the service?

Question: Is there anything else related to the services that you receive that you'd like to tell me about?

After ending the interview

Thank interviewee for participation; explain that there will be a dissemination event to which they will be invited. Check if everything is understood including consent. Would it be possible to come back to you in the future if anything is unclear on the recording? Any questions?

Interview schedule for referrers

- What has been your involvement in the X Chronic Conditions Demonstrator (X) and the establishment of the Community Resource Teams (CRTs)?
- What do you see as the purpose of X/the CRTs?
- To what extent have you been kept informed of the development of the X/CRT developments (i.e. were you consulted/given the chance to feed back?)
- What does integrated working mean to you?
- What in your opinion are the key elements of effective integrated working?
- What do you see as a) the opportunities b) the challenges of integrated working of X/the CRTs?
 - For the service
 - For health and social care practitioners
 - For clients and carers
 - For you as a GP
- How have the CRTs affected your referral process? What have been the changes, if any?
- How has X/the CRTs impacted on the services provided to people living with chronic conditions?
- To what extent do you think that your clients are aware of the changes to the provision of services?
- How will you know if the CRTs have been a success?
- How would you measure success?
- Anything else?

Interview schedule for lead agency representatives

Time of Interview:

Date:

Place:

Interviewer:

Interviewee:

Position of interviewee:

(Brief description of project)

Introduction – Thank you for agreeing to meet me etc. I'd like to begin by asking you

How do you see your role in X?

What do you see as the purpose/aim of X?

What does integrated working mean to you?

What do you see as the key elements of effective integrated working?

What do you see as the a) opportunities b) challenges of integrated working of X?

For the service

For the professionals

For the clients and carers

For you

How are voluntary services involved in the design of CCM service and delivery?

How are clients and carers involved in the design of CCM service and delivery?

How will you know whether X has been a success?

How would you measure success?

Is there anything else you would like to say about integrated working and X?

Thank you for your time etc.

Focus group schedule

Project: An Investigation of Integrated Working in a Chronic Conditions Management Service in X

Time of Focus group:

Date:

Place:

Moderator:

Focus group participants:

Introduction – Thank you for agreeing to meet me etc. I'd like to begin by asking you

How are you settling into the CRT?

How were you consulted regarding the setting up of the CRT? (and how often?)

What are the opportunities of integrated working in the CRT? – for you/for clients/carers of the service

What are the challenges of integrated working in the CRT?- for you/for clients/carers of the service

And how is integration/co-location affecting client care?

What does integrated working mean to you?

What are the key elements of effective integrated working?

How will you know if the CRT has been a success?

1. Identify health and social care practitioners' views on the challenges and opportunities of integrated working in X's chronic conditions management service

How do you see your role in X?

What do you see as the purpose/aim of X?

What does integrated working mean to you?

What do you see as the key elements of effective integrated working?

What do you see as the opportunities/challenges of integrated working of X?

For the service

For the professionals

For the clients and carers

For you

How are voluntary services involved in the design of CCM service and delivery?

How are clients and carers involved in the design of CCM service and delivery?

How will you know whether X has been a success?

How would you measure success?

Is there anything else you would like to say about integrated working and X?

Thank you for your time etc.

How do you feel about allegiance/ethos in the team? Community ethos etc.

Appendix 6: Meetings observed (August 2009 – March 2011).

Date	Title
20/08/09	Building the Locality Approach to CCM and Community Services in Armorshire Workshop
13/10/09	Owain Glyndwr LHB Primary Care and Community Services Strategic Delivery Programme Desk Top Exercise Modelling Day
16/10/09	The National CCM Demonstrator Learning Event
09/11/09	Bro-y-Grug GP cluster meeting
18/03/10	Bro-y-Grug LLT meeting
29/04/10	Armorshire County Leadership Team meeting
03/06/10	Bro-y-Grug LLT meeting
10/06/10	Collaboration Joint LLT meeting
15/07/10	Bro-y-Grug LLT meeting
29/07/10	Armorshire County Leadership Team meeting
03/08/10	CCM Demonstrator Review Visit
05/08/10	Bro-y-Grug LLT meeting – with Disability Partnership
20/08/10	Building the Locality Approach meeting
26/08/10	Collaboration Joint LLT meeting
26/08/10	Bro-y-Grug LLT meeting
09/09/10	Collaboration line-managers consultation meeting
23/09/10	Bro-y-Grug LLT meeting
30/09/10	Armorshire County Leadership Team meeting
7/10/10	CRT front-line staff consultation meeting
28/10/10	Collaboration Joint LLT meeting
28/10/10	Bro-y-Grug LLT meeting
04/11/10	Bro-y-Grug LLT meeting
04/11/10	Bro-y-Grug line-managers meeting
18/11/10	Bro-y-Grug LLT meeting
25/11/10	Armorshire County Leadership Team meeting
01/12/10	Collaboration Joint LLT meeting
13/01/11	Armorshire County Leadership Team meeting
20/01/11	Bro-y-Grug LLT meeting
27/01/11	Bro-y-Grug LLT meeting
03/03/11	Bro-y-Grug LLT meeting
10/03/11	Bro-y-Grug LLT meeting
14/03/11	Armorshire County Leadership Team meeting

17/03/11	Armorshire County Leadership Team meeting
24/03/11	Bro-y-Grug LLT meeting
31/03/11	Joint LLT evaluation meeting

Appendix 7: Individual interviews

Interviews: lead agency representatives

Pseudonym	Position	Date of interview
Gwyn Evans	Bro-y-Grug LLT Social Care Lead	11/06/10
Jo Marshall	Armorshire Collaboration Project Manager	22/06/10
Christine Thompson	Bro-y-Grug Locality Care Coordinator	02/07/10
Janice Davies	Bro-y-Grug LLT District Nurse Lead	08/07/10
David Lewis	Bro-y-Grug LLT GP Lead	05/08/10
Anne Richards	Armorshire CDM Nurse Lead	27/08/10
Carla Edwards	Tregwen LLT Social Care Lead	02/08/11
Vanessa Lewis	Bro-y-Grug LLT Business Support Officer	24/08/11
Jill Thomas	Armorshire Collaboration Social Care Lead	25/08/11
Elizabeth Jones	Armorshire Collaboration Secondary Care Lead	26/09/11
Ian Cooper	Armorshire HSCWB Partnership Officer	27/09/11
Dr. Lawrence Morgan	Clinical Programme Lead for Long Term Conditions and Community	03/10/11

Interviews: clients

Pseudonym	Age	Chronic condition(s)	Date of interview
Aled Powell	59	MS, stroke	28/04/11
Roland Phillips	75	COPD	03/05/11
Mike Scott	64	COPD	13/05/11
Tony Evans	63	COPD/heart failure	20/06/11
Hilda Jenkins	87	Arthritis, stroke.	21/06/11
John Butler	76	Diabetes	27/06/11
Stephen Price	67	Paraplegia	01/08/11
Diane Evans	83	Diabetes, COPD arthritis	29/03/12
Ray Hughes	66	COPD	02/05/12
Helen Smart	64	Diabetes	10/05/12
Jo Stephens	69	Diabetes	14/05/12
Albert Keenan	65	Diabetes	06/06/12

Interviews: carers

Pseudonym	Age	Chronic condition(s)	Date of interview
Jo Powell	57	Arthritis	05/05/11
Rhoswen Scott	66	Cancer	13/05/11
Lisa Evans	60	None	20/06/11
Jeff Stephens	70	Depression	27/06/11
Claire Price	60	None	01/08/11

Interviews: referrers to CCM service

Pseudonym	Position	Date
Dr. Jan Fielding	GP	25/10/11
Rhian Price	Practice Nurse	25/10/11
Dr. Edward Thomas	GP	4/11/11

Interviews: voluntary sector representatives

Name	Position/role	Date
Claire Peters	AAVS Partnership Manager	02/08/11
George Foster	EPP course tutor	30/11/11
Ruth Johnson	Disability Partnership Chair	23/02/12

Appendix 8: Focus groups

Focus Group 1: 10th February, 2011

Pseudonym	Profession
Paula Davis	Occupational Therapist
Janet Williams	Chronic Disease Management Nurse
Rhian Lewis	Chronic Disease Management Nurse
Jenny Cole	Social Worker
Michelle Roberts	Physiotherapist
Leslie Jones	Care Management Assistant
Rebecca Griffiths	Social Worker

Focus Group 2: 23rd March, 2011

Pseudonym	Profession
Toni Ellis	Occupational Therapist
Caroline Thomas	Social Worker
Heather Edwards	Assessor Care Manager
Rhodri Jones	Care Management Assistant
Gemma Denton	Occupational Therapy Assistant

Focus Group 3: 12th May, 2011

Pseudonym	Profession
Deborah Hale	Chronic Disease Management Nurse
Lauren Price	Occupational Therapist
Louise Thomas	Occupational Therapy Assistant
Vanessa Lewis	Care Management Assistant
Jane Field	Care Manager

Focus Group 4: 21st September, 2011

Pseudonym	Profession
Frances Evans	Senior Domiciliary Care Practitioner
Annabelle Ford	Senior Enablement Practitioner
Emma Stone	Senior Enablement Practitioner
Ruth Edwards	Enablement Worker
Helen James	Enablement Worker
Judith Price	Domiciliary Care Practitioner
Julie Morgan	Domiciliary Care Practitioner
Diane Stephens	Domiciliary Care Practitioner

Appendix 9: Armorshire Project Initiation Documents

**X Chronic Conditions Collaboration
Project Initiation Document**

Document Control

File Name	X PID
Original Author(s)	X
Current Revision Author(s)	X

Version	Date	Author(s)	Notes on Revisions
0.1	31/8/08	X	
0.2	16/9/08	X	Minor amendments / additions following initial review by X, Delivery Team Chair

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Introduction

Background

“When you always do what you always did, you always get what you always got.”

Mark Twain

The 2003 Wanless Health and Social Care Review made specific recommendations about better utilisation of community facilities and development of robust chronic conditions management services across primary and community care as part of a longer term solution of care being delivered much closer to patients’ homes when it is clinically safe and cost-effective. This is the basis on which the vision in “Designed for Life” and “Fulfilled Lives, Supportive Communities” has been based. Achievement of this vision requires a strategic shift in resource distribution from secondary care based services towards community and primary care based services.

The World Health Organisation has identified that “managing chronic conditions as the main healthcare challenge for the future”. In Wales, as with many other developed countries across the world, there is an increasing prevalence of chronic conditions, replacing the communicable and killer diseases of the past. This will be compounded by an increasingly ageing population which will have a significant impact not only on health but upon a wide range of areas including the economy, employment, transport and housing. In addition, the general population demographic trend for the workforce will result in there being far fewer people of working age and thereby available to care for the increased demand created by the ageing population.

The current health and social care delivery models are unsustainable in the medium term and action is needed to ensure all caring resources are used to best effect to provide and support care in primary and community settings.

1.2 Chronic Condition Focus

The X project will build on the chronic disease management developments implemented by the X health and social care community over the past 2 years. These initiatives have continuously shown improvements in terms of the number of emergency admissions having a chronic disease as the primary diagnosis and a reduction in lengths of stay for many of these admissions. The enthusiasm shown by all those involved in achieving these improvements will now be focused on delivering the CCM Model and Framework to ensure sustainable services for people with chronic conditions can be provided.

1.3 Approach

X has been established as a collaborative that will produce improvement by harnessing the collective wisdom and enthusiasm of participants from a wide network of multidisciplinary teams in a number of health, social and voluntary care sectors. It will draw on the experience and knowledge of experts and the evidence base to develop strategies to aid implementation of best practice.

This project will utilise an Action Research methodology and selected project management tools.

This approach will bring participatory and empowering consensus building techniques to the process of re-designing services and care delivery for people living with chronic conditions in X.

This document provides a framework for the project. Completion of the first stage will facilitate detailed planning of subsequent stages with the document evolving to reflect project progression. Detailed stage plans will be held by the project manager.

PROJECT objectives

Goals and Objectives

Goal / Outcome	Objective
<i>Improve healthy lifestyles and well being in the community</i>	• To increase the percentage of people who feel involved in their care
<i>Prevent and delay the onset and early deterioration of chronic conditions</i>	• To implement Prism across X • To improve the targeting of preventative and health promotion services •
<i>Improve quality of life for people living with chronic conditions</i>	• To increase the percentage of people living with chronic conditions sense of well-being
<i>Reduce the impact of chronic conditions on secondary care and care homes</i>	• To reduce unscheduled care consultations • To reduce the number of inappropriate emergency admissions • To reduce the number of emergency admissions where the length of stay is inappropriately prolonged (DTCO) • To reduce the number of people who have an emergency admission and are discharged to a different care setting from referral
<i>Increase self management, independence, and the participation of people with chronic conditions and their carers</i>	• To increase the percentage of people who feel informed about their condition and care needs • To provide better information resources and CCM education methods • To create capacity within the professional workforce to deliver specialist services to more people with chronic conditions in primary and community care settings
<i>Improve the quality of patient care closer to home</i>	• To increase the provision of secondary care specialist

	• resources into primary and community care • To provide additional services locally • To widen access to services locally • To increase the involvement of service users, carers and the public in developing services to meet their needs
<i>Improve prescribing and medicines management</i>	• To reduce the number of medicines management related emergency admissions for people with chronic conditions • To increase the number of people being offered and receiving regular medicines management reviews
<i>Reduce health inequalities and improve economic activity</i>	• To improve ??

Critical Success Factors

Goal / Outcome	Critical Success Factors
<i>Improve healthy lifestyles and well being in the community</i>	• Understand what services people want • Partnership working with service users and all those involved in providing their care • Develop structured, planned and systematic support and information for people and their carers • Engage service users as co-designers of new care delivery models • Identify clinical and social care professional champions
<i>Prevent and delay the onset and early deterioration of chronic conditions</i>	• Full roll-out of Prism across GP practices in X • Establishment of integrated care delivery models which include specialist services, care co-ordination and targeted health prevention and promotion
<i>Improve quality of life for people living with chronic conditions</i>	• Introduce self-monitoring and self-referral processes • Manage patient's journey through the systems and across organisational boundaries through the generic care pathway • Enable greater patient choice and access to improved care quality
<i>Reduce the impact of chronic conditions on secondary care and care homes</i>	• Offer pro-active care which utilises the most appropriate expertise or care service from the best suitable care giving agency without duplication • Ensure secondary care provides only what they need to in terms of the level of expertise or access to specific services within its setting – but offers its services to the community

	• Create systems and processes that support more integrated and co-ordinated working • Ensure executive level leadership to project goals, objectives and approach
<i>Increase self management, independence, and the participation of people with chronic conditions and their carers</i>	• Enable and empower people to make improvements to the self-care by effective signposting and access to services • Provide coherent and consistent decision support for patients, informal carers and professionals, including Prism and Map of Medicine • Ensure full engagement from primary care stakeholders
<i>Improve the quality of patient care closer to home</i>	• Engage and enable all carers to work across organisational boundaries • Provide appropriate development opportunities to carers in all sectors to enhance the appropriate skills base required to deliver the new care delivery models
<i>Improve prescribing and medicines management</i>	• Ensure people understand their medicines regime • Ensure community pharmacists are involved in the service re-design
<i>Reduce health inequalities and improve economic activity</i>	• Define an appropriate health and social care data set to support both the delivery of chronic conditions care services and monitoring of such services • Develop innovative ways to commission the new care delivery models, eg consortium of voluntary sector organisations

Principles

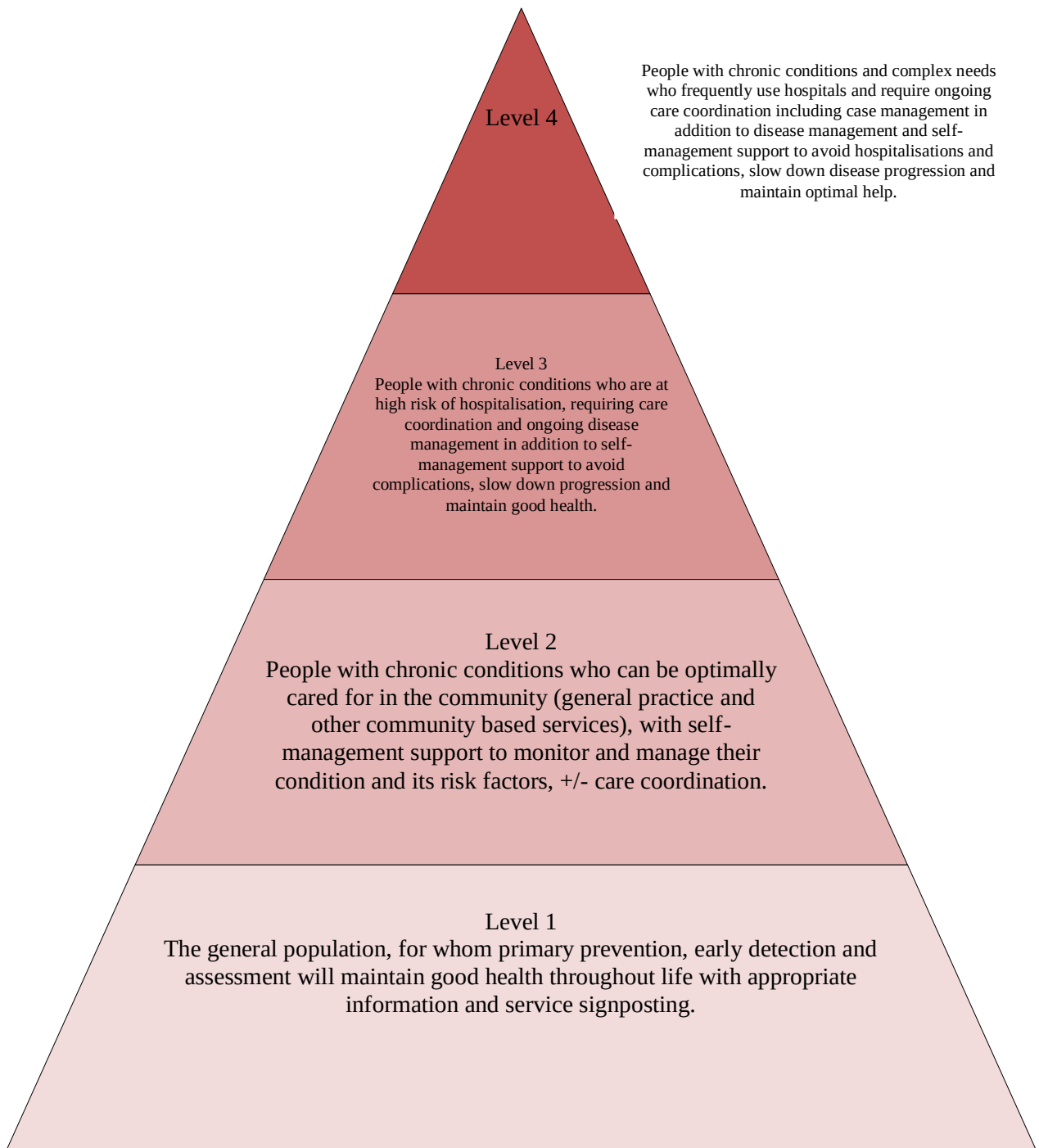
The following principles underpin all aspects of the project's strategic approach to chronic disease management and local service delivery:

- Promoting person and their carers centred care
- Promoting an active self management support approach
- Encompassing prevention across the continuum of care
- Providing equitable and timely access to appropriate services
- Promoting integrated multidisciplinary care
- Promoting care coordination and care planning
- Providing evidence based care
- Promoting effective organisational and service delivery systems that include assessment, diagnosis and chronic disease complexity stratification process
- Demonstrating effective leadership and governance
- Working in partnership and collaboration
- Demonstrating commitment to monitoring, outcomes and evaluation.

2.4 KEY DELIVERABLES for ccm model and framework approach

	Model and Framework element	Key Deliverables
1	Core CCM Team	• Agreed Core CCM Team member role and responsibilities specification • List of agreed competencies for team members • Job descriptions, person specifications and KSF outlines • Mapping of appropriate existing staff roles to new roles • Training and development needs analysis if new roles to be fulfilled by existing staff member • Suite of CCM Team operational guidelines: ○ Access 436 ○ Assessment ○ Intervention packages ○ Discharge procedure ○ Referral escalation procedure ○ Relationship with other agencies, eg housing, benefits, voluntary services • Qualitative evaluation framework, eg team member satisfaction, stakeholder / service user satisfaction, impact on working relationships • Quantitative evaluation framework, eg impact on key care delivery processes (patient referral to CCM team to delivery of agreed care package), affordability / sustainability, impact on NHS and social care utilisation targets, Prism risk score improvements
2	CCM Care Service Planning Co-ordinator	• Agreed Care Service Planning Co-ordinator role specification • List of agreed competencies • Job description, person specification and KSF outline • Mapping of appropriate existing staff roles to new role • Training and development needs analysis if new role to be fulfilled by existing staff member • Description of how to use Prism to support care service planning and co-ordination • Qualitative evaluation framework, eg postholder satisfaction, stakeholder satisfaction, impact on working relationships • Quantitative evaluation framework, eg impact on key care delivery processes (patient referral to CCM team to delivery of agreed care package), affordability / sustainability
3	Systematic locality approach to CCM	• CCM Model and Framework from the Social Care perspective • A detailed analysis of the profile of, and drivers for, demand for health and social care services

		• Active engagement of caregivers and managers in the process of reviewing how CCM resources are utilised in each locality • Development of locality networks of health and social care provision • Provision of health and social care services to meet the needs of the locality; • Locality care workforce which is matched to the needs of the population • Qualitative evaluation framework, eg quality of patient experience, level of caregiver involvement in innovation • Quantitative evaluation framework, eg care delivery in most appropriate setting, DTOC, secondary care utilisation
4	Generic Care Pathway	
5	Generic Support Worker	
6	Risk Stratification	• Prism implemented in all GP practices in X • Development of the Prism algorithm to: ○ Include A&E variables ○ Test out ‘added value’ of social care variables ○ Other in accordance with user requirements • Guidance for Care Service Planning Co-ordinator on using Prism • Guidance on using Prism for medicines management
7	IM&T	• Document describing the core CCM IM&T package, rationale and its functionality • Business case for procuring the capacity and capability to deliver the core IM&T package • Information governance guidance on sharing personal health and social care information • Findings of sharing personal health and social care information public consultation exercise •
8	Chronic Respiratory Conditions Service Development and Commissioning Directives	• Guidance / case studies on how progress on delivering and sustaining the requirements to date has been achieved • Approach, learning and outcomes on other priority directive areas yet to be agreed



3.1 *Organisational Scope*

The project will, through collaborative service re-design, implement the CCM Model and Framework and test out the various components in localities across X. It will take account of work undertaken under the Three Counties Planning Forum, Community Services Group, and Primary Care-led Locality Commissioning and Service Development plans.

3.2 *CHRONIC CONDITIONS Scope*

The project will test the components of the CCM Model and Framework for patients living with chronic conditions in the different localities across X as follows:

3.2.1 Core CCM Team – Appendix 3

3.2.2 CCM Care Service Planning Co-ordinator – Appendix 4

3.2.3 Systematic locality-led CCM care delivery – Appendix 5

3.2.4 Generic Care Pathway and associated interventions – Appendix 6

3.2.5 Generic Support Worker – Appendix 7

3.2.6 Chronic Respiratory Conditions Service Development and Commissioning Directives implementation approach – Appendix 8

3.2.7 Predictive Risk Stratification Model (Prism) – Appendix 9

3.2.8 Information and communications technologies to support information sharing and care delivery Workstream brief – Appendix 10

In addition, X established a team of 10 specialist nurses (CDM Team) to work collaboratively with other health care professionals to manage patients with COPD, Diabetes and Heart Failure. These nurses are currently predominantly disease specific.

The X project will examine how this team's expertise can be enhanced to enable patients with co-morbidity to be more efficiently and effectively managed. In addition, improvements in medicines management, personal and social care and support, together with overall co-ordination of an individual's care will be the focus of re-designing the care delivery model across the collaborative.

3.3 *IMPLEMENTATION SCOPE*

The following matrix illustrates how the objectives of the project will be taken forward in four separate, but interlinked work streams with consideration given in all activities to five sub-stream elements.

Core Work Streams					
Enabling Sub streams		Workforce	Service Planning & Delivery	Public Engagement & Involvement	ICT
	Leadership	NLIAH /	NLIAH	Community Health Council	Informing Healthcare
	Governance	Professional competencies	Care governance guidelines Standing financial instructions		Information governance
	Organisational Development & Culture	Education and training	Revision and updating of care processes		
	Research & Evaluation				
	Self Care	Education and training New roles	New services, information resources and opportunities for learning	Importance of empowerment and self care responsibility	Technologies and information sharing to support and increase levels of self care

There will be an overall project plan which will provide details of each work stream's objectives and tasks. It will be reviewed at each Delivery Team meeting and revised and updated as appropriate to reflect the project's progress and priorities. Details of specific actions which will be required with associated timescales and responsibility to deliver each of the identified tasks will be developed and managed within each individual work stream.

Terms of Reference for each of the work streams, together with those for the Clinical Reference Group are included as Appendix 11 to this PID.

The initial draft overall X work plan is included as Appendix 1 to this PID.

Stage 1	Initiation
Scope:	Set up the project management structure, associated documentation and initiate the project in line with the recommendations in the CCM Demonstrator Briefing.
Dates/Duration:	1 April – 30 September 2008
Deliverables:	1. Appoint Project Manager 2. Ministerial Launch 3. Project Initiation Document – including Work Stream membership and terms of reference, outline work plan covering Stage 1 and 2, organisational structure 4. Communications Strategy and Plan 5. Performance monitoring framework
Stage 2	Implementation of Stage 1 Plans and Stage 3 Development
Scope:	TBC following first Delivery Team meeting on 23 September
Dates/Duration:	1 October 2008 – 31 March 2009
Deliverables:	TBC following first Delivery Team meeting on 23 September

3.4 Related Projects

Projects	Expected Completion
• Individual Health Record for Unscheduled Care (IHR)	
• Predictive Risk Stratification Model (Prism)	
• Map of Medicine	
• My Health On Line (MHOL)	
• Public Sector Broadband Aggregation (PSBA)	
• Welsh Clinical Portal	
• Welsh Clinical Gateway	
• Integrated Workforce Planning Process for NHS Wales	
• NHS Reorganisation and Restructuring	
• Telecare Capital Grant Project	
•	
•	429

3.5 Out of Scope

The X project will focus only on people living in X with chronic conditions. However, it will share the learning, approach, progress and findings with not only other health organisations within the X Trust and LHB community but across Wales.

Re-designing mental health services other than including depression or dementia associated with chronic conditions where appropriate will not be examined as part of the X project.

RISKS, constraints and ASSUMPTIONS

4.1 Risk Management Approach

Risks for the project will be managed using SharePoint. The overall project risks will be highlighted in this PID and reviewed by the Delivery Team at each meeting. In addition, all work streams will draw up and maintain their own risk log on SharePoint and this will be reviewed at each work stream meeting.

All new significant risks will be incorporated into the overall project risk register which will be presented to each Delivery Team meeting. Risks will include outline mitigation plans and any impact on timescales if appropriate.

4.2 Risks

No	Risk Description	Effect of Risk	Mitigation
1	Delivery Team does not provide the appropriate level of project leadership.	Project is not successfully delivered.	Representative senior membership from key organisations. Clear roles and responsibilities for membership which is monitored.
2	Care delivery re-design does not focus on needs of people living with chronic conditions.	Care services will not meet the needs of patients and their carers.	Appropriate level of involvement from service users. Service users' views are taken into consideration in the planning, development, and implementation of any new services.
3	Impact of wider health and social care re-organisation on X.	Lack of leadership to delivery project successfully. Work stream activities	Adequate succession planning.

		affected by lack of or changes in key senior management involvement.	
4	Inadequate workforce capacity to test out new care services alongside existing services.		
5	Unrealistic expectations on scope and timescales for project.		
6	Failure of key organisations to make the X project high priority.	Project success will be adversely affected if stakeholders cannot commit to take forward initiatives.	Representative senior membership from key organisations. Regular reporting to the LSB with members used as an unblocking mechanism if necessary
7	Delays in securing any funding required to take forward initiatives.		
8	Failure to accurately measure costs and benefits		
9	Loss of staff and public trust on information governance issues		
10	Unrealistic expectations of the potential to integrate health and social care working practices and systems		
11	Failure to keep the project simple and focused on patients' requirements.	Success delivery of project objectives jeopardised.	Develop FAQs for project and specific initiatives where appropriate. Ensure benefits of objectives are identified. Ensure necessary resources to take forward objectives are provided.
12	Failure to gain support for project from care professionals	Progress on taking forward objectives will not be 'at pace'.	Adequate representative work stream membership. Comprehensive

			Communications Plan which takes advantage of all communications opportunities.
13	Too many project inter-dependencies		Inter-dependency plan
14	GPs do not agree to their information being appropriately shared to support patients with chronic conditions.		

4.3 Constraints

The project needs to recognise a number of constraints which will apply during part or the entire project. The number of dependant and inter-dependant projects within facilitating organisations, and across so many various stakeholders means that the synchronisation of all related activity will be difficult.

The most significant constrain is likely to be the available resources, particularly funding and time. Although these can be addressed within the Project it is likely that the project will be constrained by the available envelop especially financially.

4.4 Assumptions

- Continuity of key senior managers involved in leading the project
- No additional initiatives for people with chronic conditions will be prioritised by the lead organisations for the duration of the project
- Funding to take forward the agreed objectives will be allocated
- Project scope remains unchanged
- Effective communications mechanisms are established with all relevant staff
- Expectations of all stakeholders is effectively managed
- Impact of the NHS reorganisation does not destabilise frontline staff
- All staff will receive the appropriate education and training necessary to underpin the implementation of new care models, approaches, and ways of working
- Staff are motivated to engage with developing the new care models, approaches and ways of working

PROJECT ORGANISATION

5. Project structure

5.2 Roles & Responsibilities

Title	Project Manager – X
Role	The person responsible for developing, in conjunction with the Project Sponsor, a definition of the project. The Project Manager then ensures that the project is delivered on time, to budget and to the required quality standard (within agreed specifications). She ensures the project is effectively resourced and manages relationships with a wide range of stakeholders (including all project contributors). The Project Manager is also responsible for managing the work of temporary external consultants, eg researchers, allocating and utilising resources in an efficient manner and maintaining a co-operative, motivated and successful team.
Responsibilities	
• Managing and leading the project team. • Recruiting project staff and consultants. • Managing co-ordination of the partners and work streams engaged in project work. • Developing and maintaining a detailed project plan. • Managing project deliverables in line with the project plan. • Recording and managing project issues and escalating where necessary. • Resolving cross-functional issues at project level. • Managing project scope and change control and escalating issues where necessary. • Monitoring project progress and performance. • Providing status reports to the Project Sponsor. • Managing project team training within the defined budget. • Liaison with, and updates on progress to, Project Delivery Team. • Managing project evaluation and dissemination activities. • Managing external consultancy input within the defined budget. • Final approval of the design specification. • Working closely with users to ensure the project meets business needs.	

Title	Project Sponsor – x, supported by Helen Howson, WAG /x LSB Chair
Role	The person who commissions others to deliver the project and champions the cause throughout the project. They will normally be a senior member of staff with a relevant area of responsibility that will be affected by the outcome of the project. They are involved from the start of the project, including defining the project in conjunction with the Project Manager. Once the project has been launched they should ensure that it is actively reviewed. The Project Sponsor is usually the one who has to negotiate a path through the tricky diplomatic areas of the project!
Responsibilities	
• Acts as champion of the project. • Is accountable for the delivery of planned benefits associated with the project. • Ensures resolution of issues escalated by the Project Manager or the Delivery Team. • Sponsors the communications programme; communicates the programme's goals to the organization as a whole. • Makes key organisation/commercial decisions for the project. • Assures availability of essential project resources. • Approves the budget and decides tolerances. • Leads the Project Delivery Team. • Ultimate authority and responsibility for the project.	

Title	Delivery Team Member / Work Stream Lead
Role	This group, normally containing management grade staff, is responsible for overseeing the progress of the project and reacting to any strategic problems.
Responsibilities	
• Championing the project and raising awareness at senior level. • Approving strategies, implementation plan, project scope and milestones. • Resolving strategic and policy issues. • Driving and managing change through their organisation. • Prioritising project goals with other ongoing projects. • Communicating with other key organisational representatives.	

Title	Project Team Member
Role	The staff who actively work on the project, at some stage, during the lifetime of the project. This could be further broken down into specific roles as required – such as Project Administrator, etc.
Responsibilities	
Team member roles will vary depending on the type of project. Typically they might be to: • Provide functional expertise in an administrative process. • Work with users to ensure the project meets business needs. • Documentation and analysis of current and future processes/systems. • Identification and mapping of information needs. • Defining requirements for reporting and interfacing. • User training.	

Title	Project Support
Role	Responsible for maintenance of the project plan, maintenance and updating of project SharePoint website. Provides administrative support to the Project Manager.
Responsibilities	
• Sets up and manages support functions covering planning, tracking, reporting, quality management and internal communication. • Produces consolidated reporting to the Project Delivery Team, including milestone summary, key issues, risks, benefits, summary of costs incurred. • Establishes standards, tools and procedures for use on the project, including Issue, Risk, Change and Information Management. • Manages the Project Library. • Reviews project activities for compliance with procedures and standards. • Manages the support and provision of project tools and equipment. • Arranges meetings as appropriate. • Assists with the production of user documentation as appropriate. • Assists with quality assurance processes.	

Title	Work Stream Lead
Role	To identify objectives, tasks and actions, in consultation with the project manager, to deliver the necessary work stream elements of the project.
Responsibilities	
• Working with the Project Manager on definition of development requirements and priorities. • Leading the work stream and delegating responsibility for delivering elements of the work stream project plan to both the members and other work streams as appropriate. • Interfaces with other work streams. • Reporting on work stream progress to Delivery Team. • Ensuring respective member organisation senior managers are aware of work stream priorities and providing appropriate level of resource to ensure success.	

Delivery Team Membership

Project Role	Responsibility	Member	Organisation
Project Manager		X	X LHB
Project Support		TBC	TBC
Secondary care lead / senior user	Internal supplier of stakeholder resources in particular to develop, provide advice and assure the project. Represents all those who will use the final products, specifies user needs, and defines acceptance criteria, monitors quality, and signs off products as fit for purpose.	x	General Manager, Community and Intermediate Care X NHS Trust, X Division

Primary care lead / senior user	Internal supplier of stakeholder resources in particular to develop, provide advice and assure the project. Represents all those who will use the final products, specifies user needs, and defines acceptance criteria, monitors quality, and signs off products as fit for purpose.	x	Director of Nursing / Deputy Chief Executive X LHB
Social Care Lead / senior user	Internal supplier of stakeholder resources in particular to develop, provide advice and assure the project. Represents all those who will use the final products, specifies user needs, and defines acceptance criteria, monitors quality, and signs off products as fit for purpose.	x	Head of Integrated Services, X NHS Trust, X Division and X County Council
IHC Lead / senior supplier		x	Chief Executive, Informing Healthcare
NLIAH Lead / senior supplier		x	Director of Partnership Working Director of Service Development, NLIAH
LSB Link		x	
Clinical Assurance		x	Chair, Chronic Disease Management Board

Core Chronic Conditions Management Team

1 Introduction

Care is often fragmented, with a lack of effective communication across settings and providers. People with multiple chronic conditions often have to navigate a system that requires them to coordinate several disparate financing and delivery systems themselves, making it more difficult to obtain the full range of appropriate services. In addition, persons who need access to different programmes are most likely to find that each programme has different eligibility criteria, sets of providers and providers that are not linked organisationally.

No one approach to chronic disease management is necessarily better than others. The key to success is the joint development of local solutions to meet local need, and thereafter the systematic application of what has been jointly agreed, with regular monitoring and evaluation built in. The opportunity that this type of systematic approach provides for both health and well-being improvement and for prevention cannot be overstated. It requires the sustained efforts of a number of committed individuals, and a collective desire in the health and social care community to bring about change. No single factor determines success:

- Clinicians leading change – but not the exclusive province of doctors.
- A team that is interdisciplinary rather than multidisciplinary, ie members participate in the team's activities and rely on one another to accomplish outcomes rather than treat patients independently and share information about what has been done to a patient.
- Health and social care practitioners and managers working together – to identify bottlenecks in care pathways and services, to support care packages and other modernisation techniques.
- Building trust and developing good working relationships – acknowledging that there will always be variation in individual care management but this can be underpinned by the application of decision support tools and locally developed and agreed care pathways and guidelines. Such an approach will eliminate ineffective and idiosyncratic practice and support the delivery of quality care.
- Team working and sensible division of labour - more effective use of clinical resources is required. Care provided appropriately by those best placed to provide it, adds value to the service.
- Patients with co-morbidity – increasing in number and their care requires much close working between health professionals and social care organisations.

- Patient involvement – well informed patients make for better services, and allow for evolution of different models of service provision. They need help in making positive health and well-being choices about their lives and how to live them. Providing care and self management services locally is an important aspect of good care.
- Shared information – information, including clinical information, is the starting point from which innovation and change can flow. This does not necessarily mean information in electronic form or transferred electronically but it does mean identifying what patient data should be shared and co-ordinating the interactions and communications among team members.
- Systematic application – comprehensive implementation of service improvement, regular review and compliance are fundamental.

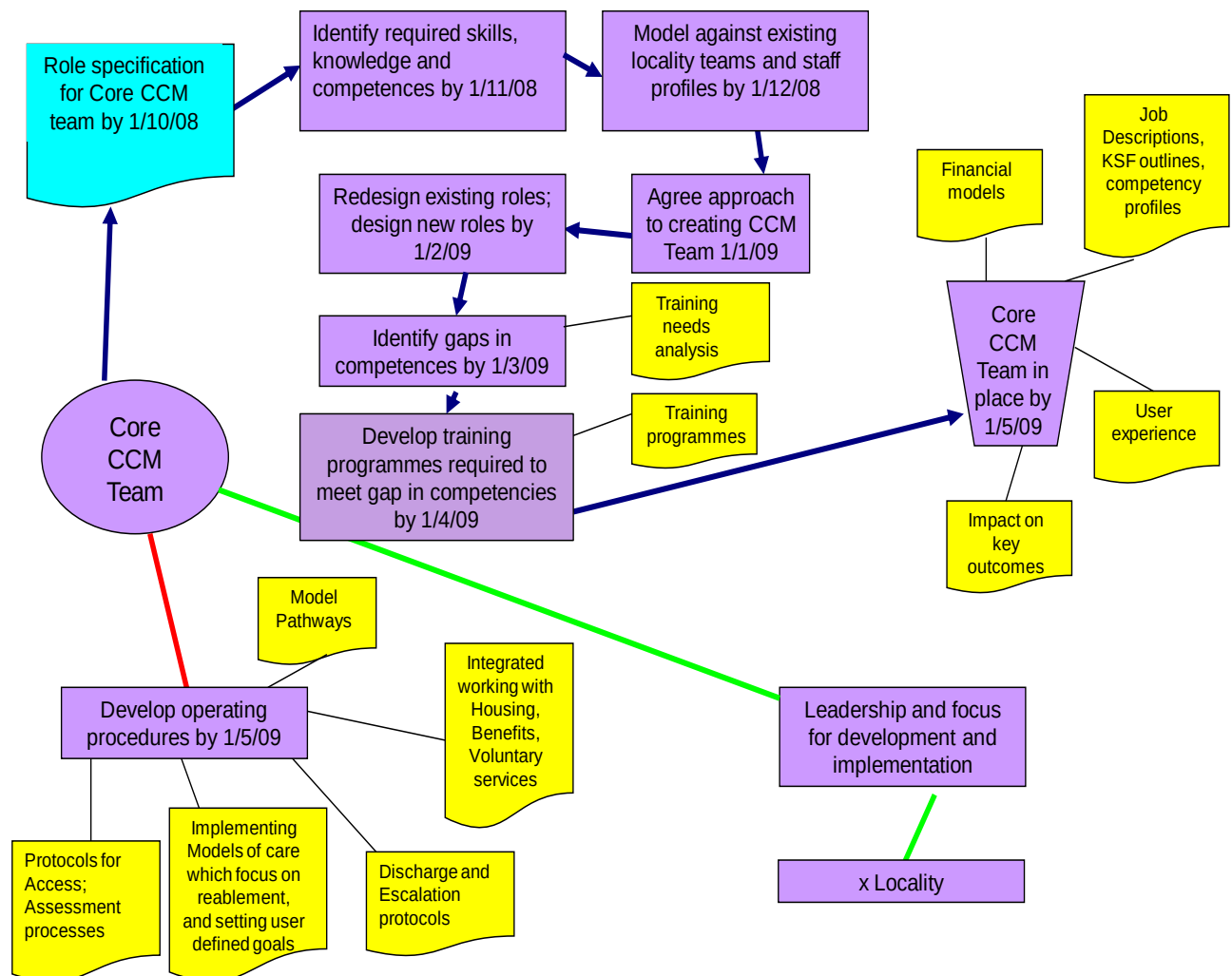
2. Key outputs / deliverables

The demonstrator will, in collaboration with the other two demonstrators provide the following products for dissemination across Wales:

- Agreed Core CCM Team member role and responsibilities specification
- List of agreed competencies for team members
- Job descriptions, person specifications and KSF outlines
- Mapping of appropriate existing staff roles to new roles
- Training and development needs analysis if new roles to be fulfilled by existing staff member
- Suite of CCM Team operational guidelines:
 - Access
 - Assessment
 - Intervention packages
 - Discharge procedure
 - Referral escalation procedure
 - Relationship with other agencies, eg housing, benefits, voluntary services
- Qualitative evaluation framework, eg team member satisfaction, stakeholder / service user satisfaction, impact on working relationships
- Quantitative evaluation framework, eg impact on key care delivery processes (patient referral to CCM team to delivery of agreed care package), affordability / sustainability, impact on NHS and social care utilisation targets, Prism risk score improvements

DIAGRAMATIC REPRESENTATION OF CORE CCM TEAM DEVELOPMENT

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Project Control

The X project forms part of the wider CCM developments in X and Wales. As part of this programme there are a number of levels of control and of governance required both internally and externally. The X project will comply with these requirements. In addition the project will follow PRINCE2 methodology, which will be used to manage its activities. Project Control methodology will therefore comply with the PRINCE2 method and the detail provided below.

6.1 Issue Control

Each Work Stream lead will create an issue log that links directly to the overall X work plan. Issues should be reported to the project manager who will escalate to the Delivery Team where appropriate. If issues arise that may affect the delivery of a key milestone an exception report should be produced.

6.2 Change Control

The X project forms part of the wider CCM developments in X and Wales and incorporate many elements of the different organisations programmes. Therefore, X change control requests must be prepared by the individual work stream leads and submitted to the project manager for consideration by the Delivery Team. In addition, a mechanism for work stream leads to forward any change request approvals relating to their organisational interdependent projects, to the project manager impact consideration and project work plan revision as necessary.

6.3 Quality Assurance

All quality control for the project will be implemented within the PRINCE2 framework. This will provide for quality approval and assessment of all project produce deliverables.

In addition the Project will not only link into existing quality processes within the lead organisations to ensure that integration and ownership can be engaged throughout the project lifecycle but the X Chronic Disease Management Board will quality assure all clinical developments.

6.4 Financial Control

The Project Manager, in consultation with the Delivery Team, will be responsible for managing the budget allocated by WAG for the demonstrator project. The CCM transitional funding will be managed by the LHB in consultation with the Delivery Team and other key stakeholders as appropriate.

7. reporting

7.1 Reporting within the Project Team

The X project forms part of the wider CCM developments in X and Wales. As part of this programme there are a number of levels of control and of governance required both internally and externally. The X project will comply with these requirements. In addition the project will follow PRINCE2 methodology, which will be used to manage its activities. Project reporting will therefore comply with the PRINCE2 method as follows.

Checkpoint reports

The Delivery Team will be sent a weekly checkpoint report giving details of activities and progress during the week together with those proposed the following week.

Highlight Reports

Each work stream will produce a highlight report monthly for submission to the Delivery Team.

Exception Reports

Will be reported as necessary within the Project

End Stage Reports

Will be reported at each stage end.

Mld Stage Assessments

Will be undertaken at an appropriate point within each stage and will be used to inform planning of subsequent stages as required.

7.2 Management Reporting

The Delivery Team and work streams will meet monthly and the Project Manager will keep the Project Sponsor / WAG Executive up to date with progress / issues as necessary through the regular All Wales CCM demonstrator meetings. In addition, approach, learning and progress will be undertaken and shared with the other CCM demonstrators and the national CCM Demonstrator lead.

8. Communication

A comprehensive draft Communications Strategy and Plan has been drawn up and is included as Appendix 2 to this PID.

The successful implementation of the X project entails major organisational change and to achieve a successful and sustaining change, effective communication and the engagement of stakeholders is essential.

In summary the included scope of the strategy and plan covers:

For patients:

- Improved quality and convenience of care closer to home
- Improved communications with health and social carers
- Confidence in the accuracy and appropriateness of information that is shared to underpin the provision of care
- Involvement in designing the new care delivery
- Reduction in care information duplication

For clinicians and social carers:

- Improved information and support through access to health and social care records
- Knowing which care providers have been involved in treating a patient
- Reduced administration and less duplication of record-keeping
- More efficient and appropriate referrals and communications of test results and discharge summaries between, for example, GPs and community workers
- Increased safety in prescribing and monitoring prescriptions, and warning about possible conflicts in treatment
- News about changing trends in treatment and care

For the Care Services:

- A transformed service focused on the individual patient with improved care experience and confidence in the service
- Greater integration of health and social care services
- Better quality information to support research, audits, and performance management

9. planning

9.1 *Approach*

The Delivery Team will be responsible for agreeing the priorities for X and the overall work plan for X will be drawn up in Word as not all partner organisations have access to Microsoft Project. Work stream leads will be required to develop, revise and update their own work plans detailing the specific actions required to deliver the tasks and objectives and reflect progress.

9.2 Milestone Plan

The draft overall project work plan is attached to this PID as Appendix 1

X Delivery Team

Terms of Reference

Introduction

The X Delivery Team has been established to take forward the Welsh Assembly Government's Chronic Conditions Management X Demonstrator which is one of the Local Service Board's (LSB) partnership priorities. As such, it will be responsible for the re-design of care services for people living with long term conditions in X, making better use of all resources available and improving care outcomes.

Purpose

The purpose of the group is to provide a forum in which the member bodies can work together to plan and oversee the delivery of re-designed services are enabled to live independent lives in the place of their choice.

Key Tasks

The Delivery Team will:

- Develop a multi-agency strategic approach to deliver agreed outcomes for the population of X through improved and modernised specialist and core services. The multi-agency strategic approach will form the foundation for any future joint planning of services.
- Monitor progress against the strategy and for improving services, and access to them.

- Ensure citizens, their carers and the wider community has the opportunity of meaningfully influencing and shaping the planning, design, provision and monitoring of local services.
- Maximise resources, including reconfiguring systems and pooled or joint budgets within the County to deliver services for people with chronic conditions.
- Co-ordinate the contribution of statutory agencies; independent sector, community and voluntary sector agencies to enhance the effectiveness of the whole system in achieving agreed outcomes.
- Ensure all partners are supported and developed to play their role in promoting independence, well-being and choice.
- Ensure service commissioners and providers are able to recognise, plan for, and respond to the individual choice of patients and the needs of the wider community and are targeted to achieving the partners' shared outcomes.
- Communicate and disseminate information about the availability of local services effectively.
- Better targeting of service delivery through effective information sharing between partners.
- Disseminate the learning, approach, and products to other CCM Demonstrators and across NHS Wales generally.

Delivering outcomes

The partnership will approve the work plans of the four work streams and will maintain an overview of performance in relation to the delivery of these plans and resultant health outcomes. These will be based upon an analysis of local need and on an understanding of community priorities. In particular, the partnership will develop and oversee the delivery of its contribution to the Local Service Board for X, working with those agencies and partnerships at the local and strategic level which need to be engaged in that work.

Membership

Each member must be at a level of seniority to have delegated decision-making responsibilities for the organisation or team they represent.

Members of the Team are to nominate substitutes where they are not able to attend future meetings of the group in order to prevent non-attendance. Any substitutes must be at a sufficiently senior level to contribute to discussions and make decisions where necessary.

The Team's membership will be formally reviewed every 6 to 12 months.

x Chief Executive, Informing Healthcare	IM&T Work Stream Lead
x Locality Manager, Health & Social Services	IM&T Work Stream representative
x, Chief Officer, Community Health Council	PPI Work Stream Lead
X Communications Officer, Trust, LHB, LA	PPI Work Stream representative
x, Director, NLI AH	SD&I Work Stream Lead
x, CDM Team Co-ordinator, LHB	SD&I Work Stream representative
x, Director, NLI AH	Workforce Work Stream Lead
x X Trust	Workforce Work Stream representative
x, General Manager, Community and Intermediate Care Services	Senior Manager, X Trust, X
x, Director of Nursing	Senior Manager, X LHB
x Head of Integrated Services	Senior Manager, X County Council
x, Head of Strategic Projects, Social Care, Health & Housing	LSB link representative
x Project Manager	In attendance
x, Project Director, x	In attendance
x, Project Director,x	In attendance

Quorum

The quorum at all meetings of the Board shall be 25% of the full membership. If, at any time, there is not a quorum present, no decisions will be acted upon without approval from other members.

Frequency of meetings

Meetings will be held monthly.

Accountability

In addition to individual accountability to the employing organisation of each representative, the Team as a whole will be accountable to the LSB. Close links will be maintained with all other partnership groups within X.

Accountability for aspects of the Team's function outside the LSB will continue to be maintained via current and future performance management frameworks for statutory partners.

Communications

The Team will ensure that communications with stakeholders, including service users and carers, are effective and in particular that there are arrangements in place to ensure that:

- the priorities of local strategic partnerships in relation to CCM are addressed
- the local strategic partnerships are engaged as appropriate in making arrangements for the delivery of X's programme locally
- the partnership will utilise existing consultation and communication mechanisms where appropriate

Administration / Secretariat Arrangements

The X Delivery Team will be administered by the LHB, who will provide administrative support for meetings such as agenda preparation, circulation and minute taking.

Agendas and all associated papers will be distributed electronically to all group members 3 working days in advance of a forthcoming meeting. Formal minutes will be produced after each meeting and will be distributed electronically to all group members. No hard copies of Delivery Team papers will be provided by the secretariat at meetings.

Service Planning and Delivery Work Stream

Terms of Reference

Purpose

The strategic objective of the CCM Service Planning Work Stream is to ensure that sustainable services are developed in line with the needs of the population of X.

Key Tasks:

- To identify and test opportunities to strengthen and improve health and social care services for CCM including telehealth and telecare, specialist services and direct access
- To re-design care delivery by establishing excellent patient-carer and organisational relationships
- To make recommendations on commissioning needs to the delivery team
- To baseline the Respiratory directive against service development and delivery in X and to prioritise recommendations to take forward within X
- To ensure the development and delivery of sustainable services that are provided at the right time in the right place for the people of X
- To ensure service developments are tested and evaluated and then implemented if of value to demonstrator
- To encourage and support successful innovative approaches are integrated into mainstream health and social care services
- To report progress to the CCM Delivery Team on a quarterly basis
- To provide evidence of improved innovative service delivery

Membership

The core membership of the work stream will be:

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x	Service and Clinical Lead, Chronic Disease Management Team X LHB
x	National Leadership and Innovation Agency for Healthcare
x	Respiratory Nurse Specialist X NHS Trust
x	General Manager, Community and Intermediate Care Directorate, X NHS Trust
x	Service Improvement Manager National Leadership and Innovation Agency for Healthcare
x	General Manager, Medical Directorate X NHS Trust
x	Acting Director of Planning and Primary Care X LHB
x	Deputy Director of Primary Care X LHB
x	Primary Care Development Manager X LHB
x	Head of Integrated Services X County Council
x	Senior Health Promotion Specialist National Public Health Service
x	Head of District Nursing X NHS Trust

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x	Acute Response Team Manager x NHS Trust
x	Consultant in Respiratory Medicine x NHS Trust
x	Consultant in Respiratory Medicine x NHS Trust 471
x	Consultant in Respiratory Medicine x NHS Trust
x	Consultant Cardiologist x NHS Trust
x	GP x
s	GP Adfer Medical Group
x	CCM Project Manager

Secretariat

This will be provided by X LHB

Attendees

By invitation.

Quorum

Half the membership with at least one representative from each of the four lead organisations, ie CHC, LHB, Trust and LA.

Meeting Frequency

Meetings will usually be held monthly.

PUBLIC AND PATIENT PARTICIPATION WORK STREAM

Terms of Reference

Purpose

To ensure that people with chronic conditions and their carers have a strong voice in the X demonstrator.

Principles

- 1 Without community engagement the care services will not respond as well as it can to the care needs and circumstances of the various communities the project is serving.
- 2 Community engagement is much more than community consultation. The former is about a continuous dialogue and the development of a good working relationship. The latter is about one party seeking the views of another at occasional intervals.
- 3 Community engagement must involve a 'dialogue of equals' – about individuals and local communities who are properly informed about their health needs and what the care services can offer. They are also empowered to talk as equals to care planners and professionals, while recognising the expertise of care planners and professionals. Equally, it is about care professionals who genuinely understand the needs and circumstances of different communities, and are prepared to recognise the experience and expertise that community members can bring to any debate.

The three main stages of engagement are:

- 1 **Information gathering** – the collection of information and data about public attitudes and requirements through surveys etc. There is no ongoing dialogue between the public and the organisation seeking the information. The public usually participate in this as individuals.
- 2 **Consultation** – members of the public and the organisations work together for a defined period to discuss a particular policy or service issue. The methods used can range from focus groups to citizens' panels. People are brought together as representatives of the demographic profile of a particular community.
- 4 **Participation** – members of the public and the organisations work together, on an ongoing basis, on a range of policy or service issues. These tend to focus on the community rather than on individuals. Community forums are an example.

The word 'dialogue' refers to the exchange of views, ideas and concerns between different groups.

Key Tasks

Members of the PPI work stream individually and together are responsible for:

- Ensuring people with chronic conditions and their carers views of service need and provision are voiced, are as representative as possible, and reflect local need.
- Ensuring sharing across local groups and communities as far as possible.
- Being a point of reference for all work streams and service providers.
- Acting as partners in the developing and shaping services related to chronic conditions.
- Participating in the development of tools and resources related to chronic conditions.

Membership

The core membership of the group will be:

x	Chief Officer, X Community Health Council
x	Public and Patient Involvement Officer, X Community Health Council
x	Head of Strategic Projects, Social Care, Health & Housing
x	Health, Social Care & Well-being Partnership Officer, CCC
x	Information Officer, Social Care, Health & Housing, CCC
x	Expert Patient Programme
x	Communications Officer, Health & Social Care, CCC
x	Head of Corporate Services, LHB
x	Consultation Manager, CCC
x	General Manager, Community & Intermediate Care Directorate, x NHS Trust
x	Chair, Health, Social Care & Well-Being Partnership
x	CDM Team Co-ordinator, LHB
x	Health, Social Care & Well-Being facilitator, CAVS
x	PPI Officer, LHB/Trust

x	Project Director
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Secretariat

This will be provided by the Community Health Council.

Attendees

By invitation.

Quorum

Half the membership with at least one representative from each of the four lead organisations, ie CHC, LHB, Trust and LA.

Meeting Frequency

Meetings will usually be held monthly.

INFORMATION MANAGEMENT AND TECHNOLOGY WORK STREAM

Terms of Reference

Purpose

To identify, develop and provide a range of technologies to support clinicians/care professionals and patients in the delivery of integrated services which aim at manage patients with chronic conditions in or as close to their home as possible.

Group Principles

- Common person identifier – NHS number (also the UPRN – unique property reference number)
- One point of entry (ie computer) – clinical portal on the secondary care health side
- Compliance with national approach to information governance, ie legitimate purpose to see and use information
- Robust and transparent way of determining priorities
- No “all singing, all dancing” IT solution
- Make best use of what we've got, providing it's good enough, through an assessment process

Key Tasks (first 6 months):

Members of the IM&T work stream individually and together are responsible for

- draw up the specification for procuring private sector capacity (including skills) for NHS systems integration and social care interoperability;
- contribute towards drawing up the stakeholder / user requirement from the ICT perspective, for the new care delivery model and identify the information governance issues associated with people delivering and receiving care within and across organisational and professional boundaries;

- create a simulated care delivery environment for people to visit to see the technologies 'in action'; and
- install and develop PRISM for all 'signed up' GP practices in X

Membership

The core membership of the group will be:

x)	Chief Executive Informing Healthcare
x	General Manager, Community & Intermediate Care Directorate, x NHS Trust
x	Medical Director X LHB
x	IHC Project Manager X NHS Trust
x	IHC Research Laboratory
x	Head of Strategic Projects, X Social Care, Health and Housing
x	Strategic IT Manager, X County Council
x	Information Governance Manager, Informing Healthcare
x	Health Statistician, Welsh Assembly Government
x	CCM Project Manager
x	Project Support Manager Informing Healthcare
x	CCM Project Manager

Secretariat

This will be provided by Informing Healthcare

Attendees

By invitation.

Quorum

Half the membership with at least one representative from each of the four lead organisations, ie CHC, LHB, Trust and LA.

Meeting Frequency

Meetings will usually be held monthly.

WORKFORCE MANAGEMENT AND DEVELOPMENT WORKSTREAM

Terms of Reference

Purpose

The strategic objective of the CCM Workforce Sub Group is to ensure the development of a flexible and sustainable workforce to support the effective delivery of the CCM identified and the Human Resource Management systems and processes to underpin effective implementation .

Key Tasks:

- the development and delivery of a strategy and action plan for the group
- to provide HR expert guidance to the Project Board and the sub groups to inform the assessment of Workforce implications of the re-design of service delivery
- to develop a communication framework to support the strategic action plan and clarify relationships with internal and external stakeholders
- to report progress to the Project Board on a quarterly basis
- consider the organisational development, and potentially organisational change implications of the integrated workforce model and develop plans to address these issue
- consider the education and training implications of the project and develop plans to address these issues

Membership

The core membership of the group will be:

x	Workforce Development Manager, X NHS Trust
x	General Manager, Community and Intermediate Care Directorate, X NHS Trust
x	Deputy Director HR X NHS Trust
x	Workforce Development Manager
x	Director of Partnership National Leadership and Innovation Agency for Healthcare
x	Head of Occupational Therapy Health and Social Care - X
x	Head of Speech and Language Therapy
x	Head of Podiatry
x	
x	Nurse Director, X LHB
x	Service and Clinical Lead, Chronic Disease Management Team X LHB
x	Head of District Nursing, X NHS Trust
x	Senior Health Promotion Specialist X Public Health Team
x,	CCM Project Manager

Secretariat

This will be provided by X NHS Trust

Attendees

By invitation.

Quorum

Half the membership with at least one representative from each of the four lead organisations, ie CHC, LHB, Trust and LA.

Meeting Frequency

Meetings will usually be held monthly.

Appendix 10: Armorshire CDM Team Information Pack for General Practice

CHRONIC DISEASE MANAGEMENT TEAM

INFORMATION PACK FOR GENERAL PRACTICE

INDEX

Philosophy and Objectives of the Chronic Disease Management Team

Criteria for referring to the COPD Specialist Nurses

Criteria for referring to the Diabetes Specialist Nurses

Criteria for referring to the Heart Failure Nurses

PHILOSOPHY AND OBJECTIVES OF THE CHRONIC DISEASE TEAM

Team Philosophy

To improve the management and care of patients with chronic disease across primary and secondary care, working in partnership with the patient, carers, and multi-professional teams including the voluntary sector.

The team will deliver education, support and high quality care to patients with chronic disease in a variety of settings and work with carers and other health professionals, to maintain a seamless approach to chronic disease management.

Objectives of the Team

- Advising patients on self management.
- Identifying patients at risk of a crisis or exacerbation.
- Providing care to prevent emergency admissions.
- Providing education on chronic disease management for patients/carers/relatives in particular COPD, Diabetes and Heart Failure.
- Educating and supporting health professionals in the community.
- Improving access to health care for hard to reach/disadvantaged groups.
- Supporting community projects that encourage healthy lifestyles

2. CHRONIC DISEASE MANAGEMENT SERVICE FOR PEOPLE WITH COPD

The x chronic disease management (CDM) service has been established to improve patient care in the community and to ensure that appropriate care of patients can be effectively managed within the community. The service includes a team who provide a service for people with chronic obstructive pulmonary disease (COPD).

The COPD team comprises :

- | | |
|---|---|
| x | Chronic Disease Management Team Coordinator |
| x | COPD Nurse Specialist |
| x | COPD Nurse Specialist |
| x | Respiratory Physiotherapist |

This team is able to deliver education, support and high quality care to COPD patients in their own homes and work with carers and other health care professionals to maintain a seamless approach to COPD management.

Services provided include:

- Assessment of patients and their conditions
- Establishment of patients care plans
- Advising patients on self-management
- Providing care to prevent emergency admissions
- Identifying patients at risk of exacerbations
- Advising on exercise and pulmonary rehabilitation
- Providing education on COPD for patients/carers/relatives
- Educating and supporting health professionals in the community

ACCESSING THE COPD SERVICE

Access to the team is by direct referral from GP, consultant, respiratory nurse, practice or district nurse providing the following criteria are met,

The patient is

- Under care of a X GP
- COPD diagnosis is confirmed by spirometry
- On optimal therapy as per NICE guidelines + COPD continuing to deteriorate

AND includes at least one of the following

- The patient is for discharge post acute admission to hospital
OR
- The patient has had multiple exacerbations in previous 12 months

- The patients is currently receiving a high number of drugs on repeat prescriptions in need of a medication review

Referrals should be accompanied by:

- Recent Spirometry or Chest X-ray results (if this is not possible then this should be made clear on the referral)
- Full list of medication
- Full Medical History

Acute Episodes:

The CDM team can provide support to known patients during acute episodes but will only assess new patients who are acutely ill through hospital admission and existing acute referral procedures.

Contact us

Our aim is to be a resource to people with COPD and those involved in their care. If you have any questions about either our service or individual cases please contact us and we will do our best to help you.

3. CHRONIC DISEASE MANAGEMENT SERVICE FOR PEOPLE WITH DIABETES

The x chronic disease management (CDM) service has been established to improve patient care in the community and to ensure that appropriate care of patients can be effectively managed within the community. The service includes a team who provide a service for people with Diabetes

The Diabetes team comprises:

- x Chronic Disease Management team leader
- x Diabetes Nurse Specialist
- x Diabetes Nurse Specialist
- x Diabetes Nurse Specialist

This team can deliver education, support and high quality care to Diabetes patients in their own homes and work with carers and other health care professionals to maintain a seamless approach to Diabetes management.

Services provided include:

- Advising patients on self-management
- Providing care to prevent emergency admissions
- Identifying patients at risk of crisis
- Advising on exercise, X-pert education program and nutrition

- Providing education on Diabetes for patients/carers/relatives
- Educating and supporting health professionals in the community

ACCESSING THE DIABETES SERVICE

Access is by direct referral from GP, consultant, diabetic nurse, practice or district nurse provided the following criteria are met:

- Confirmed diagnosis of Diabetes (as per WHO diagnostic Criteria)
- People with Type II Diabetes
- Patients of GP Practices within X NHS boundaries
- Patients agreeable to being seen by a CDM Diabetes Nurse
- Suitability for referral to CDM team:-
 - Hard to reach groups i.e.
 - Residential/Nursing Homes
 - Sheltered Accommodation
 - Day Care Centre
 - Housebound
 - Post MI patients
 - Frequent Admissions
 - Persistent DNA's

The following exclusion criteria will apply:

- Gestational Diabetes
- Type II Diabetes and Pregnant
- < 25 Years inc. DNA's
- Able to attend clinics
- Patients not agreeable to being seen by a CDM Diabetes Nurse
- Severe cognitive/sensory disturbances known to be potential risk to lone workers i.e. evidence in notes to indicate risk (see lone worker policy)

Referrals to the team should include:

- recent test results i.e. HBA1C, Cholesterol, LFTs, U&Es and also an indication if they are home blood glucose monitoring
- Full list of medication
- Full medical history
-

Acute Episodes:

The CDM team can provide support to known patients during acute episodes but will only assess new patients who are acutely ill through hospital admission and existing acute referral procedures.

Contact us

Our aim is to be a resource to people with Diabetes and those involved in their care. If you have any questions about either our service or individual cases please contact us and we will do our best to help you.

4. CHRONIC DISEASE MANAGEMENT SERVICE FOR PEOPLE WITH HEART FAILURE

The x chronic disease management (CDM) service has been established to improve patient care in the community and to ensure that appropriate care of patients can be effectively managed within the community. The service includes a team who provide a service for people with Heart Failure.

The Heart Failure team comprises:

x	Chronic Disease Management team leader
x	Heart Failure Nurse Specialist
x	Heart Failure Nurse Specialist
x	Heart Failure Nurse Specialist

This team can deliver education, support and high quality care to Heart Failure patients in their own homes and work with carers and other health care professionals to maintain a seamless approach to Heart Failure management.

Services provided include:

- Advising patients on self-management
- Providing care to prevent emergency admissions
- Running Nurse led Up titration clinics to optimise treatment
- Running open access diagnostic clinics in conjunction with the cardiologists
- Identifying patients at risk of crisis
- Advising on exercise and nutrition
- Providing education on Heart Failure for patients/carers/relatives
- Educating and supporting health professionals in the community

ACCESSING THE HEART FAILURE SERVICE

Access is by direct referral from GP, consultant, Heart Failure nurse, practice or district nurse provided the following criteria are met:

- Confirmed documented diagnosis of Heart Failure
- Heart Failure Caused by Left Ventricular Systolic Dysfunction (as confirmed by echocardiography, coronary angiography, radionuclide ventriculography)

- Patients of GP Practices within X LHB boundaries
- Patients agreeable to being seen by a CDM Heart Failure Nurse
- Documentation of :-

CXR report

ECG (Normal CXR and ECG makes diagnosis of heart failure unlikely)

Full Blood Count

Glucose

Thyroid Function Test

Lipids

Urinalysis

Spirometry (if appropriate)

Echo if available

Urea and Electrolytes

The following exclusion criteria will apply:

- Patients not agreeable to being seen by a CDM Heart Failure Nurse
- Severe cognitive/sensory disturbances known to be potential risk to lone workers i.e. evidence in notes to indicate risk (see lone worker policy) and determined by the Mini-Mental State test.
- Major communication problems
- Other life – threatening illness requiring palliative care (advanced malignancy)

All referrals to be accompanied by:

- echocardiogram, or coronary angiography or radionuclide ventriculography. (Where this has taken place and GP practice has a copy)
- Full list of medication
- Full medical History

Acute Episodes:

The CDM team can provide support to known patients during acute episodes but will only assess new patients who are acutely ill through hospital admission and existing acute referral procedures.

Contact us

Our aim is to be a resource to people with Heart Failure and those involved in their care. If you have any questions about either our service or individual cases please contact us and we will do our best to help you.

Appendix 11: Project timeline.

Date	Event
March – May 2009	Interview/acceptance for PhD scholarship. Attendance of Older People Research and Development Network (OPAN) event: ‘Narratives of Ageing’ at the National Waterfront Museum, Swansea (10/04) Attendance of Royal College of Nursing International Research Conference (27/04). Commencement of PhD. First meetings with academic supervisors Professor Joy Merrell and Dr. Susan Philpin (01/04). Commencement of preliminary review of literature on chronic conditions management (CCM) and integrated working. Familiarisation with case study research to support later fieldwork and analysis. Commencement of introductory chapter. Training with Swansea University (SU) School of Health Science (SHS) librarian – use of databases for literature searching (03/04). Postgraduate induction day (27/04). EndNote bibliography training (29/04). Submission of Research Progress Report to Wales Office of Research and Development for Health and Social Care (30/05). Academic supervision: (22/04; 13/05).
June – August, 2009	Attendance of Clinical Research Collaboration (CRC) Cymru training – Update on Good Clinical Practice (02/06). Discussion on integrated working (by telephone) with Helen Dickinson of Birmingham University Health Services Management Centre (08/06). Attendance of SU SHS Research Interest seminar – application tips for ethical approval; focus on auto-ethnography in health science research (12/06). Meeting with Nick Andrews, Planning Officer for Older People, Swansea Social Services (23/06). Meeting with Caroline Davies, Expert Patients’ Programme lead trainer/co-ordinator (24/06).

	Attendance of CRC-Cymru Communications Skills workshop (25/06). Orientation meeting at Armorshire LHB HQ in Tregwen with Professor Joy Merrell and local collaborators Jo Marshall and Anne Richards (10/07). Preparations for ethical review, including: drawing-up of bilingual participant information sheets/consent forms/letters of invitation and preparation/submission of online applications to LREC and NHS Trust R & D Office. Preparation of methodological framework for the study, including theoretical basis and historical use of case studies. Analysis of theories/techniques re. use of interview, focus groups and observation in qualitative research. Attendance of NVivo training (24/07). Attendance of LREC review (20/08). Submission of Research Progress Report to Wales Office of Research and Development for Health and Social Care (31/08). Academic supervision: (19/08). Fieldwork/data collection: Non-participant observation of workshop: 'Building the Locality Approach to CCM and Community Services in Armorshire' (20/08).
September – November, 2009	Meeting with Billie Hunter, professor of midwifery at SU SHS to discuss use of focus groups (07/09). Lecture to 2nd year Swansea University pre-registration nursing students on CCM (51 students) as part of their community placement study day (14/09). Meeting with Anne Richards (local collaborator) and Mark Kingston [real name] (CCM demonstrator evaluator/researcher) at SU SHS (meeting also attended by academic supervisors Dr Susan Philpin and Professor Joy Merrell) (25/09). LREC ethical approval granted (following amendments to information sheets, introductory letters and consent forms) (05/10). Meeting with Professor David Hughes to discuss post-devolution health/social care policy (06/10). Attendance of lectures at SU School of the Environment and Society: MSc in Social Research (given by Dr. Paul Ransome) (26/10).

	Lecture on CCM (to September 2008 cohort of pre-registration nursing students at SU SHS) (03/11). Submission of Research Progress Report to Wales Office of Research and Development for Health and Social Care (30/11). Academic supervision: (02/10; 14/10; 27/11) Fieldwork/data collection: Home visits with Armorshire Chronic Disease Management (CDM) nurses (11/09). Attendance of Heart Failure clinic at Tregwen Hospital with Armorshire CDM nurse (18/09). Attendance of Primary Care and Community Services Strategic Delivery Programme Desk Top Exercise Modelling Day (13/10). Attendance of National CCM Demonstrator Learning Event, Temple of Peace, Cardiff (16/10). Non-participant observation of 'GP cluster' meeting (09/11) . Attendance of CCM Demonstrator Research and Evaluation Workshop (30/11).
December 2009 – February 2010	Approval granted for the study from the All Wales Primary Care Research Management and Governance (RMG) Office. Due to weather conditions, return to college (following Christmas break spent at parent's in Gloucestershire) delayed until mid-January. From beginning of February, further absence from college due to illness (urinary infections); unable to attend lectures, academic supervision, training or other events. Further orientation to the study area: visit to the Armorshire CCM oxygen-therapy clinic. Main focus of study: completion of preliminary literature review as part of transfer report to proceed to PhD status at the end of first year (delayed due to illness). Second draft of literature review sent to supervisors; literature review for inclusion in the transfer report for submission at end of March. Submission of Research Progress Report to Wales Office of Research and Development for Health and Social Care (28/02).
March – May 2010	Submission of literature review and formal transfer report; study approved for progression to the second year. Development of schedules for individual interviews. Transcription of LLT meetings. Thematic analysis

	commenced. Field notes and early findings logged in case study database. Requests made to the study site for documentary material, including minutes and agendas of meetings. Ongoing health problems due to recurrent urinary infections and skin rashes (referred for bladder scan and to dermatologist). Meeting with Nick Andrews, Planning Officer for Older People, Swansea Social Services (with Professor Joy Merrell) (20/05). Submission of Research Progress Report to Wales Office of Research and Development for Health and Social Care (25/05). Academic supervision: (26/03; 05/05). Fieldwork/data collection: Non-participant observation of Bro-y-Grug LLT meetings (18/03; 29/04). Meeting with demonstrator Locality Services Planning Co-ordinators (12/05).
June – August 2010	Individual interviews conducted with Demonstrator Project Manager and Local Collaborator and all members of the Locality Leadership Team (LLT) (see below for dates). All interviews transcribed verbatim; thematic analysis ongoing. Non-participant observation of LLT meetings, Armorshire County Leadership Team meeting and WAG Chronic Conditions Management (CCM) Demonstrator Review Visit. Case study database regularly augmented with documentary evidence, including meeting agendas/minutes and local and national strategies/guidelines related to demonstrator project. Thematic analysis ongoing in consultation with academic supervisors. Preliminary findings of the study displayed in poster presentation at Swansea University SHS Research Day. Abstract submitted for poster presentation at November International CCM Conference (Cardiff). Methodology and methods chapter commenced, for September submission to academic supervisors. Continued health problems (diagnosed with epididymo-orchitis) and skin infection. Appointments made to see consultant dermatologist and referral made to consultant urologist. Submission of Research Progress Report to Wales Office of Research and Development for Health and Social Care (31/08).

	Academic supervision: (08/06; 12/07; 21/07; 24/08). Fieldwork/data collection: Non-participant observation of: Bro-y-Grug LLT meetings (03/06), (15/07), (05/08), (26/08); Armorshire County Leadership meeting (29/07); CCM Demonstrator Review visit (03/08); 'Building the Locality' meeting (20/08); Joint LLT meeting (26/08). Interviews with: Gwyn Evans, Bro-y-Grug LLT Social Care Lead (11/06); Jo Marshall, Armorshire Collaboration Project Manager (22/06); Christine Thompson, Bro-y-Grug Locality Co-ordinator (02/07); Janice Davies, Bro-y-Grug LLT District Nurse Lead (08/07); Carla Edwards, Tregwen LLT Social Care Lead (02/08); David Lewis, Bro-y-Grug LLT GP Lead (05/08); Vanessa Lewis Bro-y-Grug LLT Business Support Officer (24/08); Jill Thomas Armorshire Collaboration Social Care Lead (25/08); Anne Richards, Armorshire CDM Nurse Lead (27/08).
September – November 2010	Ongoing attendance of: LLT meetings; County Leadership Team meetings; Community Leadership Team meetings. Attendance of Community Resource Team (CRT) line-manager and front-line professional team building workshops. Case study database regularly updated. Thematic analysis of data ongoing. Drafts of methodology/methods chapter submitted to academic supervisors. Recruitment for next phase of study commenced: focus groups with CRT front-line health and social care professionals. Continued health problems (epididymo-orchitis and skin problems). Consultations with dermatologist (25/10/10) and urologist (15/11/10). Cystoscopy appointment: 10/12/10). Attendance of Community Therapists Network Annual Conference, Birmingham. 'Managing Long-Term Conditions in the Community' (10/11). Submission of Research Progress Report to Wales Office of Research and Development for Health and Social Care (30/11). Academic supervision: (21/09; 20/10). Fieldwork/data collection: Non-participant observation of: CRT line-manager meeting (09/09); Bro-y-Grug LLT meetings (23/09), (04/11); County Leadership Team meeting (30/09); CRT Team-building workshop (07/10);

	Community Leadership Team meeting (28/10); Joint LLT meeting (28/10).
December 2010 – February 2011	Thematic analysis completed for interviews with Demonstrator Project Manager, CDM Lead and LLT members. Ongoing attendance of: LLT meetings; County Leadership Team meetings; Community Leadership Team meetings. First focus group of Community Resource Team (CRT) front line health and social care professionals completed. Analysis of documentary evidence ongoing. Updating of literature review/methodology ongoing. Ongoing recruitment for participants for three further focus groups, including newly identified allied health care professional support workers. Consideration of possible theoretical/thematic frameworks in view of evidence of so far. Continued health problems (epididymo-orchitis and skin problems). Further urology appointment scheduled for March 7th. Submission of Research Progress Report to Wales Office of Research and Development for Health and Social Care (25/02). Academic supervision: (08/12; 14/01; 18/02). Fieldwork/data collection: Non-participant observation of: Bro-y-Grug LLT meeting (09/12), (20/01), (27/01); County Leadership Team meeting (13/01). Focus group: CRT front-line health and social care professionals (10/02).
March – May 2011	Demonstrator programme completed on 31st March. Non-participant observation of meetings ceased from this date. Three focus groups (of four planned) completed, transcribed and thematically analysed. Three (of twenty planned) interviews with service users of the CRT completed, transcribed and thematically analysed. Two (of ten planned) interviews with informal carers of CRT clients completed, transcribed, and thematically analysed. Recruitment of clients and carers ongoing. Case study database updated and amended in view of new data (ongoing).

	Full data analysis of all parts of data collection begun, allowing multi-stakeholder perspectives to be considered from all levels of involvement (i.e. governmental, managerial, front-line staff, clients and informal carers). Request made for extension to PhD studentship (due to recurrent health problems and delays in establishment of CRT) (20/04). NVivo training (17/05). Presentation of initial finding to SU College of Human and Health Sciences Research Interest Group (25/05). Submission of Research Progress Report to Wales Office of Research and Development for Health and Social Care (31/05). Academic supervision: (10/03; 25/03; 15/04). Fieldwork/data collection: Non-participant observation of: Bro-y-Grug LLT meetings (03/03), (10/03), (24/03); County Leadership Team meeting (17/03); CCM demonstrator review meeting (31/03). Focus group: CRT front-line health and social care professionals (23/03), (12/05). CRT service user interviews: (28/04), (03/05), (14/05). CRT informal carer interviews: (05/05), (14/05).
June – August 2011	Seven (of twenty planned) CRT service user interviews and six (of ten planned) CRT informal carer interviews completed, transcribed and thematically analysed. Interviews with: Health and Social Care Facilitator, Armorshire Association of Voluntary Services; Locality Manager of CRT; Head of Integrated Services in Armorshire; CRT Business Support Officer. Extension to PhD granted, July 12th. Submission of Research Progress Report to Wales Office of Research and Development for Health and Social Care (25/08). Academic supervision: (01/06; 13/07). Fieldwork/data collection: CRT service user interviews: (20/06), (21/06), (22/06), (01/08). CRT informal carer interviews: (20/06), (27/06). Interviews with: Health and Social Care Facilitator, Armorshire Association of Voluntary Services (2/08)

	Locality Manager of CRT (02/08); CRT Business Support Officer (24/08); Armorshire head of integrated services (25/08).
September – November 2011	Final focus group with CRT front line health and social care professionals, giving total of 25 participants over four focus groups. Interviews with two GP and one District Nurse referrer to CRT. Interview with Health, Social Care and Wellbeing Partnership Manager. Interview with Clinical Programme Lead of Long Term Conditions and Community for the Demonstrator Programme. Interview with senior manager Local Health Board. Meeting with Principal Researcher, Chronic Conditions Management Demonstrator. Thematic analysis is ongoing. Lecture to SU nursing students on health and social care policy re. Partnership working (06/10). Attendance of: MSc. Healthcare Management session, SU College of Human and Health Sciences (06/10), (13/10); MSc. Public Health and Partnerships in Care session, SU College of Human and Health Sciences (07/10), (14/10). Teaching of MSc. Public Health and Partnerships in Care sessions, SU College of Human and Health Sciences (21/10), (11/11). Poster presentation at Swansea University College of Human and Health Sciences Conversazione Conference (21/11). Submission of Research Progress Report to Wales Office of Research and Development for Health and Social Care (22/11). Academic supervision: (20/09; 18/10; 17/11). Fieldwork/data collection: Focus group: CRT front-line health and social care professionals (21/09). Interviews with: senior manager, Armorshire LHB (26/09); Health, Social Care and Wellbeing Partnership Manager (27/09); Clinical Programme Lead of Long Term Conditions and Community for the Demonstrator Programme (03/10). Interviews with: District nurse referrer to CRT (24/10); GP referrers to CRT (25/10), (04/11). Meeting with Principal Researcher, National CCM Demonstrator Project (26/10).
December 2011 – February 2012	Draft chapters of introduction, literature review and methods/methodology completed. Continued recruitment of client/informal carers and referrers (recruitment problematic).

	Synthesis of analysis from data sources. Commencement of findings chapters. Facilitator of workshop-session on patient/carer involvement in management of care of people living with neurological conditions at 'Developing Neurology Services – Addressing the Needs of Patients Conference' (organised by: Centre for Long-Term Conditions, Swansea University/Primary Care Neurological Society/Wales Neurological Alliance) Cardiff (02/12). Request for further extension to study (related to health issues and delays to demonstrator project). After long-term absence, Dr. Susan Philpin leaves study as academic supervisor. Professor David Hughes agrees to join the study in supervisory role. Submission of Research Progress Report to Wales Office of Research and Development for Health and Social Care (26/02).. Academic supervision: (15/12) Fieldwork/data collection: Interview with Chair of Carmarthenshire Disability Coalition for Action (23/02).
March – May 2012	Four more service user interviews completed, transcribed and thematically analysed. Second interview with Project Manager. Draft versions completed of: introduction; literature review; methodology and methods; background and contextual issues. Request to delay submission of final report to Wales Office of Development for Health and Social Care (due to recurrent ill-health problems, illness of Dr Susan Philpin, delays to demonstrator project). Submission of Research Progress Report to Wales Office of Research and Development for Health and Social Care (30/05). Academic supervision: (01/03; 08/03; 04/04; 03/05). Fieldwork/data collection: CRT service user interviews: (29/03), (02/05), (10/05), (14/05). Interview with Project Manager (30/04).
June – August, 2012	Request for delay of submission of final report to Wales Office of Research and Development for Health and Social Care granted (25/07). Draft versions of the following four chapters completed: introduction; literature review;

	methodology and methods; background and contextual issues. Writing of Chapter Five: Regional and Local implementation of the Welsh National CCM Demonstrator: Structural Issues; rough drafting of further two findings chapters. Presentation of study at 1st Regional European Sigma Theta Tau Conference: Diversity Across Europe, Implications for Nursing (14/07). Three monthly report submitted to Wales Office of Research and Development for Health and Social Care (30/08). Academic supervision: (12/06; 20/06; 09/07; 08/08; 16/08). Fieldwork/data collection: CRT service user interview (06/06).
September – November 2012	Writing up of Chapter Five. Academic supervision: (18/09; 24/10; 07/11). Three monthly report submitted to Wales Office of Research and Development for Health and Social Care (30/11).
December 2012 – February 2013	Writing up of Chapter Six: findings/discussions of the process of implementing the reconfigured integrated chronic conditions management service. First full draft of chapter to be submitted to academic supervisors in March. Academic supervision: (06/12; 14/01), (05/02). Request for extension of submission of thesis to Swansea University (due to health problems, illness to Dr Susan Philpin and delays to demonstrator project) (04/12). Request granted (17/12). Mother diagnosed with breast cancer (February). Three monthly report submitted to Wales Office of Research and Development for Health and Social Care (15/02).
March – May 2013	Draft of Chapter Six submitted to academic supervisors. Working title: The demonstrator project and integration: clarity and consistency versus ambiguity and flux. Chapter includes findings/discussions of the first part of the process of implementing the reconfigured CCM service. Chapter Seven in progress, working title: The demonstrator project and integration: the local interpretation Academic supervision: (07/03), (11/04). Three monthly report submitted to Wales Office of Research and Development for Health and Social Care (03/06).
June – August 2013	Following mother's diagnosis with cancer in February, extended periods of time spent at her

	home in Nailsworth, Gloucestershire. Academic supervision (04/06).
September – November 2013	Writing up of findings/discussion chapters. Progress seriously affected by personal issues (see above). Request for further extension to the final submission-date of PhD thesis to (06/09) due to mother's cancer diagnosis (granted: new submission date: 31 st September, 2014). Regular contact with academic supervisors by telephone. Three monthly report submitted to Wales Office of Research and Development for Health and Social Care (30/11).
December 2013 – February 2014	Writing up of findings and discussion chapters ongoing. Conclusion and introductory chapters to write. Regular contact with academic supervisors by telephone.
March – May 2014	Writing up of all chapters ongoing. Regular contact with academic supervisors by telephone
June – September 2014	Writing up of all chapters ongoing Notice of intention to submit PhD thesis submitted (16/07). Regular contact with academic supervisors by telephone. Thesis submitted, 31 st September.

Appendix 12: Codes, categories and themes.

Code	Category	Theme
		CHANGE
Driver/catalyst	Demonstrator Project	
Scope/time factors		
Test-bed		
Strategy/operation		
Contextual/time factors		
Individual services		
Anxiety/pessimism/unwillingness to change	Barriers	
Change-fatigue		
Status-quo/history		
Contextual/time factors		
Personal agendas		
Professionals hierarchies/rules		
Roles	Culture	
Education		
Sea-change		
Imperative		
Team ethos		
Leadership	Facilitators	
Teamwork		
Shared-vision		
Trust		
		INTEGRATION
Status quo	Barriers	
Street-level bureaucracy		
Professional culture		
Protective practice		
Concurrent projects		
Bureaucracy		
Geographic locations		
Pre-existing culture	Facilitators	
Pre-existing services		
Leadership		
Knowledge-base		
Context		
Co-location		
Co-ordination	Community Resource Team	
Holistic approach/client		479

needs/contextual needs		
Support		
Network of care		
Co-location		
Context		
Peer support		
Engagement/involvement		
Duplication/streamlining	Opportunities/challenges	
Resources		
Professional engagement/development		
Client/carer independence		
Holistic care		
CRT establishment	Operational	
Context		
		STRATEGY
Locality approach	Flexibility	
Learning		
Care co-ordination		
Leadership		
Time-frames	Top-down	
Structures		
Leadership/management		
Understanding		
Ideology		
Client/carer engagement	Bottom-up	
Front-line professional engagement		
Voluntary/third sector engagement		
Awareness	Holistic-thinking	
Scope		
Care co-ordination	Operation	
Leadership		
Front-line professionals		
Buy-in	Locality Leadership Team	
Membership		
Anecdotal evidence	Measurement	
Quantitative measurement		
Qualitative measurement		
Independent existence		
		COMMUNICATION

Language	Integration	
Opportunistic dialogue		
Cultural shift		
Language	Change	
Client/carer experience		
Structures		
Responsiveness		
Understanding		
Systems	Information	
Integration		
Change		
		INVOLVEMENT
Participation	Active/passive/tokenistic	
Engagement		
PPI		
Involvement		
Consultation		
Hard-to-reach	Labels	
Awkward		
Age		
Gatekeeper	Barriers	
Finance		
Access		
Communication		
Culture		
Culture	Facilitators	
Access		
Support		
Realistic response		
Funding		
Advocacy		
Impairment	Hierarchy	
Service user		
Service providers		
		EMPOWERMENT
Control	Self-determination	
Consulting	Tokenism	
Rights	Restriction	
Labels		
	Barrier	
Low expectations		
Service-centred		
Age		
Language		
Imbalance		
Communication lack		

	Facilitator	
Relationships		
Respect		
Support		
Living environment		
Information		
Impairment	Hierarchy	
Service user		
Service provider		