

**The DWP funded and NHS delivered Condition Management Programme:  
Lessons Learned**

This paper may be of interest to

DWP when considering partnership delivery models with other Government Departments  
Other Government Departments who may be considering similar cross working and  
funding arrangements

Work Programme Providers and other parties regarding the provision of Health Related  
Support to people on Working Age Benefits who have a health condition or disability that  
affects their ability to work

**Contents:**

Glossary of Terms.....	3
Aim of this paper: .....	4
Background: .....	4
Summary of Findings & Lessons Learned.....	5
Cross Government National Partnership Working .....	5
Regional & Local Partnerships .....	7
Funding and Financial Risk Management .....	7
Information Management & Data Security.....	9
Premises .....	9
Staffing.....	10
Clinical Governance & Effectiveness .....	11
Evaluation .....	12
CMP Exit .....	13
Future opportunities to exploit CMP learning .....	15
Conclusion .....	15
Annex 1 .....	17
CMP Lessons Learned - Detailed Feedback.....	17
Annex 2 .....	29
Case Studies .....	29

## ***Glossary of Terms***

ATOS	<a href="#">Atos Healthcare</a>
CBT	Cognitive Behavioural Therapy
CMP	Condition Management Programme
COPM	Canadian Occupational Performance Measure
CORE	Clinical Outcomes for Routine Evaluation
DA	Devolved Administrations
DH	Department of Health
DWP	Department for Work and Pensions
ELPHIN	East Lancashire Pathways Health Information Network
ESA	Employment and Support Allowance
ESF	Exit Strategy Framework
GB	Great Britain
GP	General Practitioner
HB	Health Board
HMRC	Her Majesty's Revenue and Customs
HO	Head office
HR	Human Resources
IAPT	<a href="#">Improving Access to Psychological Therapies</a>
IB	Incapacity Benefit
IBPA	Incapacity Benefit Personal Adviser
JCP	Jobcentre Plus
JCP led PtW	Jobcentre plus led Pathways to Work
JMG	Joint Ministerial Group
JSA	Jobseekers Allowance
LHB	Local Health Board
MI	Management Information
MoU	Memorandum of Understanding
NHS	National Health Service
PCT	Primary Care Trust
PL PtW	Provider Led Pathways to Work
PtW	Pathways to Work
RAD	Risk Assurance Division
SG	Steering Group
TOR	Terms of Reference
UCB	Unacceptable Customer Behaviour
VfM	Value for Money

***Aim of this paper:***

1. This paper summarises the different partner experiences and details the main learning points from the delivery of the National Health Service (NHS) delivered Condition Management Programme (CMP) within Jobcentre Plus Pathways to Work (JCP led PtW). It is important to understand that this is not a full evaluation of the programme but a snapshot of the views, opinions and experiences of those involved on what worked well and what could have worked better. As its focus is partnership working it does not evaluate the clinical benefits of CMP or clinical lessons learned.

***Background:***

2. JCP led PtW was a DWP programme for people claiming incapacity benefits (and later Employment and Support Allowance [ESA]) that was piloted in three Jobcentre Plus districts - one in England, Scotland and Wales respectively from October 2003 and expanded to 7 districts in April 2004. It was extended and expanded further to 40% of the country by October 2007. Provider Led Pathways to Work (PL PtW) was rolled out in the remaining 60% of the country from October 2008.
3. A range of voluntary choices were offered, within JCP led PtW one of which was CMP which was designed to meet the key aim of PtW to offer support to help the customer manage their health condition more effectively to bring them closer to the labour market.
4. CMP was developed by a Joint Ministerial Group, that included DWP, DH and Welsh and Scottish health representatives. The clear steer from the JMG was that CMP would be a partnership between DWP, DH, NHS, and JCP. CMP would be developed and delivered - to meet the needs of local populations, whilst satisfying the agreed core principles. DH lead the development of CMP, in partnership with JCP and the NHS
5. CMP covered mild to moderate cases of the 3 main health conditions cited in IB claims – mental ill health, musculo-skeletal disorders and cardio-respiratory conditions. The main aims were:
  - To help IB customers to better understand and better manage their condition in the work environment;
  - To help IB customers feel more confident about returning to work; and to
  - To enable customers when in work to feel more confident and expert about negotiating with their employer;

These principles were met by all CMPs but each was set up to meet the needs of the local customer group so the individual service design model varied greatly.

6. The case studies in [annex 2](#) provide examples of the type of provision offered and how the programme helped move customers into a position where they could more readily move into work.
7. JCP led PtW ceased on 31 March 2011 as part of the introduction of [Get Britain Working](#) measures and the [Work Programme](#)

### ***Summary of Findings & Lessons Learned***

(See [annex 1](#) for detailed feedback on heading areas below)

### **Cross Government National Partnership Working**

8. The NHS delivered CMP was considered to be an <sup>1</sup>innovative, if not unique, model of cross government delivery. The Department for Work and Pensions (DWP) funded the provision and the NHS delivered the provision in partnership with Jobcentre Plus. As an agreement between Government departments and with health being a devolved responsibility, the provision could not be delivered through a legally binding commercial contract. Instead it was delivered initially, through a memorandum of understanding (MoU) then on expansion through a funding agreement. This agreement was amended following DWP audit recommendations and delivery continued under a Partnership Agreement
9. The terms of the agreement changed from the original MoUs to the Partnership Agreement and some Primary Care Trusts (PCTs) felt that the exit settlement failed to honour the spirit of the original approach, (where exit costs had not been raised) that CMP would be delivered at no financial risk or cost to the NHS. However, all partners continued to deliver CMP and work to local partnership agreements.
10. The Partnership was managed at a National Level through a Steering Group. This consisted of Jobcentre Plus policy, DWP strategy and Finance, DH lead, Scottish, Welsh and English Regional representatives plus on a rota, local representatives from the region where the Steering Group met.

---

<sup>1</sup> [Inter-agency Cooperation and New Approaches to Employability Colin Lindsay, Ronald W. McQuaid and Matthew Dutton Social Policy & Administration iss 0144–5596 DOI: 10.1111/j.1467-9515.2008.00634.x Vol . 42, No. 7, December 2008, pp. 715–732](#)

## The Condition Management Programme: Lessons Learned

11. A national network – England, Scotland and Wales – of CMP managers was established, which maintained links between the DH and local sites.
12. From 2002 until 2007, there were quarterly PtW managers meetings facilitated by the project. At these meetings, the live running PtW managers ‘buddied’ with those Districts who had not yet gone live. Both these meetings and the buddying system were proven to be very successful. These were in addition to the twice yearly PTW /CMP managers meetings
13. After handover to live running PtW managers were engaged at a national level mainly through emails and bulletins and shared effective practice in this way.
14. Joint National Conferences and training events were held to share effective practice, and also to enhance partnership working by gaining an understanding of the issues that both parties needed to address. No national conferences were held after 2009, initially because the policy about future funding for Pathways to Work was still being developed and after May 2010, because the Government’s spending challenge meant that such conferences could no longer be held.
15. The DH and JCP leads met regularly on both a formal and an ad hoc basis to seek / agree a joint national policy approach to any issues that arose.
16. In the final stages the exit from CMP was managed through the Exit Strategy Framework (ESF).
17. On a couple of occasions sensitive communications were not circulated simultaneously or were cascaded erroneously. This created anxiety that required careful management from the national leads.

### Lessons learned

- **DWP is a GB wide organisation whereas Health is devolved. Government departments must take devolution and the different cultures and internal structures into account when planning joint working. Eg: the role of the DA reps at the Steering Group is different from a Regional rep as they represent the DA policy as well as the operational views from their country.**
- **There has to be a willingness and commitment at a national strategic level in each department to keep the partnership working during times**

**of dispute or uncertainty. The relationship between national leads is critical in terms of shared goals, priorities and integrated thinking.**

- **Expectations have to be managed - the structures put in place at the beginning of a project need to be reviewed as they may not always continue to meet needs as a partnership matures, e.g. resources, priorities etc.**
- **Governments and government policies change. As the arrangement cannot be legally binding both parties must enter into the partnership knowing that no guarantees can ever be given about the terms remaining unchanged. ( see [Exit Strategy](#) section)**
- **Communications need to be consistent and cascaded simultaneously through an established hierarchy e.g. the NSG TOR should include delegate responsibilities re confidentiality; National leads should ensure joint communications are cascaded simultaneously.**

## **Regional & Local Partnerships**

18. Local Steering Groups were also set up. Changes to personnel or different ways of working presented challenges in some areas, but the overall consensus was that relationships were in general excellent and collaborative in the true sense of the Partnership word.

### Lessons Learned

- **It is important to invest time in local partnerships. The local partnership between the two partners is as important as the national one**

## **Funding and Financial Risk Management**

19. The initial CMP funding model included start up costs and then moved to a budget based on an annual forecast and reimbursement of actual costs through a quarterly invoice process.

20. DWP Finance and Risk Assurance were involved in the process from the set up and pilot stage. Finance participated in weekly telekits, monthly meetings, JNSG, and Joint Ministerial Group meetings.

21. As stated in the [NHS summary](#) the funding arrangements in the early stages of the project 'sites were given a fair amount of latitude to enable a rapid kick start.' DWP audit and governance requirements saw a tightening up of the

process, including more formal checking. DWP auditors did accept that, as an equal partner, the NHS internal governance processes, as agreed by Parliament did not require audit by DWP. This meant that mutual trust and light touch financial governance processes were possible.

22. There were some issues with the tightening up of the funding arrangements for a few CMPs, some general concerns and requests for clear guidance. The final partnership agreement and finance guidance were produced to address this. In general the more accountable process was adopted effectively. At all times the principle of mutual trust steered the governance process.
23. The CMPs that did not fully endorse these changes chose to continue delivery in a professional manner, fully participating in the partnership arrangements. However the exit costs issue, although resolved as far as possible at the time by reference being made to the exit strategy and possible 12 months notice, did cause some CMPs to conclude that the spirit of partnership had been adversely affected by these changes. It would not have been possible to negotiate the exit any further within the political context at the time but it must be noted that this conclusion may have been prevented had that been possible.
24. Although the actual cost of CMP was generally less than the forecasts, there was no strong drive from the centre, until the final 6 months, for JCP districts to look for efficiency savings from their the local CMPs.

### Lessons Learned

- **While recognising that the ministerial drive is imperative, partnership and policy decision making must be subject to robust governance and financial agreement.**
- **All parties to an agreement have to accept that provision and arrangements are subject to shifts in policy requirements / directions. Partnership agreements provide more flexibility but any arrangements made under them will be subject to such changes. All parties to the agreement must ensure that any changes are fully understood.**
- **If it is known that any unease about complex or contentious issues remains it should be fully addressed and resolved before handover to live running. It is important to resolve issues at the time they occur, and if possible, future proof solutions to prevent difficulties at a later date ([See in particular exit section](#)).**

- **Both partners must look for savings constantly and demonstrate value for money throughout the life of the agreement.**

## **Information Management & Data Security**

25. A range of different databases were used to manage customer records. There was no consensus over whether a centrally imposed records process would have been helpful. However, electronic storage of records by whatever process helped with the efficiency of service delivery.
26. A data sharing system: ELPHIN was developed in East Lancashire and was used throughout as an effective internal database by some CMPs. However issues regarding the sharing of sensitive data that was not necessary for the delivery of CMP meant JCP withdrew from using it as a joint integrated system.
27. Data security standards were met by both parties. A government drive to improve data security and protect sensitive and personal information resulted in a tightening up of sharing information in the later stages of the programme.
28. The costs of developing a secure robust national system at the start of any project that requires the sharing of sensitive/personal information are probably too prohibitive for the investment, since the life of the provision will be unknown at that stage. However any exchange of sensitive information should be agreed by all parties and approved by the necessary experts.
29. The process for sharing sensitive information on Unacceptable Customer Behaviour (UCB), although addressed during the project stage, was not finally approved until after Jobcentre Plus led Pathways to Work was handed over to live running

### Lessons Learned

**Data security should be reviewed regularly to ensure it continues to meet national standards of both partner organisations**

### **Premises**

30. CMP was delivered either in Jobcentre Plus Premises; suitable premises identified by the NHS or leased premises. The decision was made locally depending upon local circumstances. Each had benefits and drawbacks. Clearly using existing JCP premises was the cheapest option and generally

worked well until the impact of the economic downturn on estates capacity put this arrangement under pressure in some districts.

31. [Research](#) (see section 3.4) shows that location did affect participation, but not because it was in Jobcentre Plus premises or not. Convenience and comfort were more important.
32. Some CMPs were unable to tie in their lease period with the end of CMP and sought authority to extend beyond that date. This was mainly due to the uncertainty when leases were up for renewal, about any possible extension of the provision beyond December 2010 and resulted in unavoidable additional costs. However some leases were extended beyond December 2010 without central authorisation.

### Lessons Learned

- **The provider should not enter into any costs, including lease arrangements, which extend beyond the known funding end date unless given clearance by the budget holder because of exceptional circumstances.**

### **Staffing**

33. JCP advisers were recruited mainly from within the existing JCP cadre and trained to a very high standard, though newer recruits towards the end of PtW did not always receive the full learning routeway. At times this resulted in issues around inappropriate referrals or insufficient referrals to CMP.
34. CMP staff were recruited in line with the relevant NHS HR policies. JCP locally had to authorise the cost for the position, but were not involved in the recruiting process, except the initial recruitment of the CMP manager because of the critical partnership element in their role. Some JCP districts may have also been involved in recruiting new CMP managers when the incumbent left.
35. In some districts CMP staff were also involved with the Fit for Work Programme and although the two areas of work were very similar they had different funding streams
36. There were some issues in managing staffing and recruiting CMP staff during the time of uncertainty about funding and the wind down. For example maintaining short term contracts was not possible because employment law converts these into permanent staffing contracts over time. Locum staffing was necessary and useful in some circumstances, but was not appropriate in all circumstances

37. The appreciation of the different HR policies that governed each PCT/HB/LHB and the differences between England Scotland and Wales came into full focus during the exit process

#### Lessons Learned

- **There were no issues regarding JCP staffing levels but staff must have access to relevant training for their role at all times.**
- **As adviser experience may vary over time managers should provide familiarisation opportunities for staff as well as offering standard learning & development. As well as increasing adviser knowledge and confidence this builds up good local relationships.**
- **When staff are employed part time for two different projects such as CMP & Fit for Work it is important that systems are put in place to ensure correct segregation and funding of duties**
- **Any partnership must recognise that each PCT/HB/LHB is governed by their own HR policies & for Wales and Scotland, DA policies, particularly regarding redundancy, and the NHS wide Agenda for Change. This principle must apply in cross government agreements and be factored in to any issues around recruitment, retention and exit issues and costs.**

#### **Clinical Governance & Effectiveness**

38. This paper does not aim to identify the clinical lessons learned. The NHS held full responsibility for this aspect of the delivery of CMP. Full details can be found in [annex 1](#). DWP accepted that they had no expertise or authority in this area. This is the only approach possible on clinical governance and effectiveness when working with the NHS to deliver support to vulnerable claimants.

39. The NHS always ensured that clinical governance; the fundamental principle of 'do no harm'; and voluntary treatment principles steered any developments.

#### Lessons Learned

- **The roles and responsibilities of each partner have to be understood from the outset EG; JCP was responsible for identifying and referring potential participants the NHS was responsible for the clinical governance of the provision without interference.**
- **Any one wishing to deliver provision needs to establish if it is subject to clinical governance that meets the necessary clinical standards.**

- **The ‘do no harm’; and voluntary treatment principles should be embedded in the service delivery model and audited by a suitably accredited company such as the NHS.**

## Evaluation

40. There was awareness from the outset that evaluation was required. DWP evaluated Pathways and all of the choices packages. DH funded the national CMP evaluation which was monitored and reviewed by the DH research team. DH also funded the local evaluations.
41. Several local and PCT commissioned evaluations have been conducted. These small scale studies found that CMP was, in general, very popular & effective in addressing participants’ confidence and ability to manage their condition. Some local longitudinal studies also showed up to 33% of participants were in employment within 2 years of completing CMP
42. The DWP evaluation: <http://research.dwp.gov.uk/asd/asd5/rports2009-2010/rrep582.pdf> findings are summarised below

*The voluntary nature and lack of pressure upon participation was seen as very important as was flexibility of provision as customers’ personal circumstances, in particular their health condition, can fluctuate over time .CMP was seen as having a number of benefits over health services, with its focus on condition management rather than medication, an opportunity to be seen quickly, and to spend plenty of time with a CMP practitioner which helps to address health conditions in depth. Customers emphasised the impact of CMP in terms of improved confidence and self-esteem, and improved ability to deal with stress and anxiety on a day-to-day basis. These kinds of impacts were felt to have come about through better management of mental health conditions, rather than physical health conditions. Indeed, some customers with physical health conditions were disappointed with the support they had received from CMP Customers frequently reported their wish for more support at the end of CMP: either a continuation of more of the same support to build on perceived progress, or support to address areas of unmet need.*

43. CMP was also assessed within the evaluation [Can we estimate the impact of the Choices package in Pathways to Work?](#) which found that:

*No difference in employment can be seen for those individuals who participated in the CMP while benefits receipt is higher for a longer period,*

*with exit rates from IB remaining significantly negative (-9.5 percentage points) up to 12 months after the claim and the differences remaining negative (though not significant) thereafter. In contrast those who choose to participate in CMP are much more likely to state an improvement in their health condition (+6.1 percentage points).*

44. The decision about the future of CMP was initially tied up with the wider decision about the future of /replacement for Pathways to Work. It was then reviewed under the Coalition Government's decision to fold existing provision into the Work Programme. As the Work Programme was to be delivered under the 'Black Box' model, providers could not be mandated to provide specific support, so there was never a contractual obligation to deliver CMP or similar within the Work Programme.
45. The DWP, when deciding which provision to fund outside the Work Programme looked at the cost of delivering job outcomes. Although there is evidence to show its value to participants in other ways, because CMP was not designed to deliver job outcomes but to move the participant nearer to the labour market, there was not sufficient evidence to show that it offered value for money in terms of measurable job outcomes.

#### Lessons learned

- **Clear performance indicators, including value for money, should be set before provision starts and any evaluation should examine the effectiveness of performance against these measures and not against other criteria. These should not be targets but any MI should be able to fully support cost benefit analysis.**
- **Continuous administrative assessment of employment outcomes would have helped to assess the effectiveness of CMP in employment terms.**

#### **CMP Exit**

46. The CMP exit strategy was governed by the relevant section of the National & local partnership Agreements:

*Jobcentre Plus will aim to provide PCT/HB/LHBs with a minimum of twelve months notice of termination of funding.*

*At the point of notice, the PCT/HB/LHB will work with Jobcentre Plus to develop an exit strategy in the most cost effective way. The National CMP Steering Group will review the exit strategy.*

*Funding available during the period of notice will be based on actual spend during that period and will be paid quarterly in arrears in line with the Partnership Agreement / Exit Strategy on the production of the [relevant/agreed] invoice. Any significant additional costs will be supported by an exceptional business case agreed by the National CMP Steering Group. E.g. a defined contribution to overall redundancy costs related to the length of service of staff with Pathways CMP.*

47. The aim to provide 12 month notice could not be met because of the wider political context. Initially DWP/JCP did not give 12 months notice in December 2009 because ministerial discussions about the future of Pathways to Work were on going. This decision was made in March 2010 - CMP was to be extended to March 2011 then replaced with a different model of Health Related Support.
48. Following the May 2010 election, the new Coalition Government reviewed existing and implemented new policies. The final decision to extend & end CMP on 31 March 2011 was made in August 2010 as part of the wider Work Programme/Get Britain Working policies.
49. Despite this uncertainty, in general the partnership working was at its most cooperative and effective during the exit, though in some areas it was strained.
50. It was a very sensitive time as many people felt very differently from DWP policy makers about the objectives; VfM perceptions and the decision to end such an effective programme. There were genuine concerns that good positive outcomes, particularly in the clinical area, were being ignored and risked being lost. The decision also directly affected individuals' employment, particularly as the exit occurred at a time of reduced redeployment opportunities within the NHS.
51. The exit arrangements were agreed mutually, by a majority of the Joint National Steering Group, following a clear governance process that satisfied both DWP audit standards and NHS HR policies.
52. There were however, disputes between JCP/DWP and a minority of PCTs/HBs/LHBs about the proportion of exit costs that DWP should meet. These disputes may not have arisen if the exit costs liability had been fully articulated and mutually agreed at the beginning of the programme and if DWP had been able to give the full the 12 month notice period (which was an aim not a guarantee) within the partnership agreement.

### Lessons Learned

- **When setting up a partnership agreement between government departments / agencies all parties must recognise that the agreement is not legally binding. They should accept from the outset that that no guarantees can ever be given about the terms remaining unchanged, but that full consultation will take place to ensure consensus where possible and a clear dispute process when a consensus cannot be reached.**
- **All parties to an agreement have to accept that provision and arrangements are subject to shifts in policy requirements / directions. Partnership agreements have no legal status so any arrangements made under them will be subject to such changes.**

### **Future opportunities to exploit CMP learning**

53. Throughout its time CMP was considered to be an innovative programme, both in terms of the way it was delivered through partnership and the content and effectiveness of the programme itself.
54. Although the decision was made not to continue with this model of health related support, it is the sincere wish of those who delivered CMP that the innovation and the benefits, particularly clinical, it brought to participants, are not lost.

### **Conclusion**

55. This delivery model was expensive and its cost effectiveness, in terms of measurable job outcomes, could not be disaggregated from other interventions and activities undertaken by the participant. This however should not distract from the positives that have come out of the experience.

*Many of the innovative features of the programme (such as flexible approaches to the recruitment, remuneration and deployment of expert NHS staff) would not have been achievable under more rigid contractual models, and the level of expertise and credibility brought to the CMP by health professionals would not have been available without the active participation of the NHS.*<sup>2</sup>

---

<sup>2</sup> [Inter-agency Cooperation and New Approaches to Employability](#) Colin Lindsay, Ronald W. McQuaid and Matthew Dutton  
Social Policy & Administration iss 0144-5596 DOI: 10.1111/j.1467-9515.2008.00634.x Vol. 42, No. 7, December 2008, pp. 715-732)

## The Condition Management Programme: Lessons Learned

56. The overriding conclusion from most partners and participants is that CMP was clinically effective; providing a positive experience from the participant's perspective. The experiences, both clinical and partnership should not be lost but be drawn on by others.
57. If a similar programme were to be introduced by these two partners, it would have to acknowledge that the nature of both the NHS and Jobcentre Plus has changed over the past few years, and that a new set of challenges would arise

Elaine Randall December 2011

## **CMP Lessons Learned - Detailed Feedback**

### **Cross Government Partnership Working**

#### **DH view**

From a DH perspective - the equal partnership for developing and delivering CMP from pilot to live running has been very successful. The importance of allowing time for gaining an understanding of how each organisation works, their values and standards cannot be underestimated. In order to facilitate working relationships between different government departments, different NHS Trusts in an area, between NHS clinicians and JCP, it was important to have a clearly identified national leadership and communication process.

#### **NHS summary**

The core of the process has been the working relationship between the NHS and JCP. This has been effective because of hard work and commitment on both sides. Liaison has taken place both at national and local level, and we believe that setting aside 'silo thinking' has been essential. Both general goodwill and detailed management have been needed. Jointly with JCP we have managed a number of challenges:

- the design of the programmes and the customer pathway
- the appropriateness and volume of referrals
- the consistency of message given to customers
- the communication and administration processes related to customers
- the use of premises
- the management of budgets and funding
- the risks – clinical, business and political of the programme.

Joint local steering groups have been important. Where this process has been interrupted or weakened, it has created difficulties.

#### **Partnerships and strategic relationships – NHS and others**

The other central relationships have been those between CMP services and their NHS host bodies, which have been complex and varied. Political structures have influenced the CMP relationships differently in England, Scotland and Wales.

However, similarities and differences between programmes have not always followed national boundaries.

Where programmes have been hosted by a single trust, but cover the geographical area of several trusts, this has raised concerns about risk-sharing

Relationships with other stakeholders have included both loose networks, and firmer neo-contractual relationships.

### **Some local Jobcentre Plus views:**

- The local District PtW Manager and CMP Manager was a very successful partnership – respective teams met regularly, worked closely together and fostered a trusting and positive relationship.
- Excellent working relationship in true collaborative working
- Excellent partnership and strategic relationships developed and maintained from Executive to Operational levels
- The overarching impression of our involvement with CMP is one of mutual cooperation and collaboration in the true sense of the Partnership word. The professionalism and standard of service our customers enjoyed was second to none and data to provide evidence on outcomes has been made available and stands as a testament to the quality and effectiveness of the provision in moving customers forward into the world of work.

### **National Jobcentre Plus views:**

- Retaining the experienced and committed strategic lead at DH was vital for the continuity of the provision when PtW was handed over from Project Status to Live Running and through to exit. This position was key to the partnership
- The local and national steering group structure ensured appropriate and prompt identification, escalation and resolution of issues

### **The benefits**

Jobcentre Plus fully endorses the following summary provided by the NHS.

The benefits of the co-operation have been:

- employment and health outcomes, as reported within the evaluations which would not otherwise have been achievable
- building on the established work of DEA and PAs - a humanised and supportive process to challenge the assumption of a life on incapacity benefits

## The Condition Management Programme: Lessons Learned

- the opening of other gateways between the benefits and health agencies – for instance CMP has helped JCP to link to IAPT and other health services. Also benefits issues for long term recipients outside of CMP have been discussed and resolved because of more frank and cordial inter-agency relationships
- The strengthening of a government-wide approach to work and health issues.
- Some opportunities have perhaps been under exploited.

Additionally

- A greater understanding of each other's role and the importance of the joint agenda to improve each customer's/patient's opportunities.

### **National, Regional & Local Sharing**

#### **NHS summary**

CMP national network meetings were used to share good practice and to identify common difficulties. They also helped in identifying issues which needed to be raised at a national level with JCP. In the developmental stages, we were able to compare our similarities and differences, and understanding the origins of these. This allowed us to question our own local practices and adopt learning from other sites. Regional groupings were also helpful in strengthening good practice, allowing for meetings and shared events.

Telephone conferencing was helpful in the later stages, but it is unlikely that it would have been sufficient in the earlier stages.

#### **Some local JCP views**

- Steering Group established, chaired by PCT Director and Senior JCP Manager
- Communication Strategy in place early in the programme led to continued operational/communication meetings across the 5 NHS Boards.
- Close working arrangements facilitated the development of the "Walking the Line" Pilot. Partnership between JCP, NHS, ATOS Healthcare & Scottish Government targeting trainee GPs in a programme that introduced "employability" to the "health and wellbeing" agenda
- Local CMP Steering Group largely ineffective in strategic terms, CMP and PtW teams took the lead.
- Communications to national groups has been problematic especially through the representative group when it seemed that only one district view was ever gleaned and minutes or outcomes seldom shared with those not attending (CMP feedback)

## **National Jobcentre Plus Views**

- Good practice was shared effectively at the early stages of the project. Good communication links, such as the National Conferences and bulletins/ joint notes were key to this.
- There was less need to share good practice after the handover to live running, primarily because most districts and CMPs had already passed this on. The SG approach was effective during the project stage of CMP but was less relevant after live running, until exit, as most issues were resolved through local negotiation and individual escalation or joint communications
- The CMP National Group was a very effective lobby group for escalation of issues through the DH lead to JCP.
- After handover, the strong successful personal relationship between the JCP and DH lead was key in maintaining effective communications

## **Funding and financial Risk Management processes**

### **NHS summary**

In the early set up of the programme, sites were given a fair amount of latitude to enable a rapid kick start. Audit and accountability processes were brought in some time later, and at the time this raised a degree of anxiety. Although too rigorous and cautious approaches might have stifled the speed of development, the need for accountability could probably have been woven in earlier on. The processes such as 10% checks on referrals and invoices have ensured clarity and have been well handled on both sides. National issues on funding have been well handled by JCP, though at times there has been anxiety within the NHS agencies, and discussion and negotiation at all levels has been needed.

There was a high level of willingness to work across organisational boundaries, and to share risks, even though this might have raised anxieties within parts of the host NHS trusts and within JCP. Without this, getting the programmes started would have been difficult.

The process for information sharing on potentially violent customers could have been developed earlier in the life of the programme.

NHS individual views:

Clearer central steer on cost reduction to enable programmes to develop systems resulting in a leaner but still effective pathway of care. We were never given a chance to "see if we could do it cheaper". I often had an underspend

(prior to invoicing on actuals), but no-one seemed to link this to any financial feedback

### **Some local Jobcentre Plus views**

- Invoice process was outsourced by PCT on a Shared Service arrangement, too many tiers involved, We received reminders for outstanding amounts before we had received the original invoice. Checking process was labour-intensive
- The invoice process has worked well with spreadsheets being submitted to a central point each quarter, checked and then agreement for invoice to be submitted. District Manager has authorised all payments which are then passed for payment via Paisley and Cardiff. Budget and spend monitored on a regular basis
- Invoicing and reimbursement system was always problematic and would probably have been done better through a central point.
- Regular monitoring of financial spend against budget.
- financial risks of overspend where well managed and under budget but could have been better value for money if expenditure reduction and service delivery methods could have been looked at earlier for efficiency savings rather than just when CMP were running down.
- NHS.net not considered by DWP to be a secure network, resulting in costly clerical and courier alternative
- PVP process changes not compatible with NHS processes
- Risk management approach adopted for all aspects e.g. performance, staff health & safety including PV notifications.

### **National Jobcentre Plus Views**

- At handover, there was an agreed process in place for budget management that was agreed at Permanent Secretary level (due to the RAD audit nil assurance.) This process was signed up to by finance /legal/RAD and by CMPs
- although it would have been beneficial to introduce a robust system from the onset it is unlikely that any organisation undertaking a pilot can invest the time and money in a comprehensive IT solution
- It is important when entering a relationship of equals to accept a level of mutual trust to enable light governance, however this does not allow either partner to abdicate their responsibility to manage the funds to the highest standards

## The Condition Management Programme: Lessons Learned

- The funding change issues were not fully resolved at handover from Project to live running. To some extent this caused some of the CMP regional representatives to be wary of the JCP National approach on subsequent issues.
- The tightening up of data security arrangements had a major impact on the way sensitive information was transferred between CMPs and JCP districts.
- The PVP process was not fully resolved at handover and took up a considerable amount of work at Jobcentre Plus National level
- This was the first partnership working provision with DWP being the major fund holder. Finance community had to develop new processes to manage the recharge process.

### **Information management & Data Security**

#### **NHS summary**

Access to data channels (3G cards, secured web interfaces etc) has had to be resolved where staff needed to work from remote bases. Accessing network access in JCP premises has been technically possible, but very difficult to achieve.

Information sharing with Jobcentre Plus has sometimes been complicated by the fact that there is no simple secure electronic route between the agencies.

NHS individual views:

Establish a clear, simple, national minimum data set and consistent Management Information BEFORE implementation to enable large cohort research from a central start point

Reduce costs by establishing a safe, reliable referral distribution system across gov. departments

A process for tracking the outcome for users of the service would have been welcomed by CMP managers, and could have contributed to identifying which elements of service were most cost effective.

#### **Some local Jobcentre Plus views**

- MI was administered locally using ELPHIN system, contracted from UCLAN. (there should have been a national standard programme made available to ensure consistency)

- Notwithstanding security issues, process to send referral forms via Fully Tracked Documented TNT Service to CMP was labour intensive and very costly. Should have been a steer from HO to get CMP destinations added to Courier Distribution list.
- NHS.net not considered by DWP to be a secure network, resulting in costly clerical and courier alternatives

### **National Jobcentre Plus Views**

- The project who had responsibility from PtW between 2002 – 2007 had investigated the use of more effective methods of data transfer, and worked closely with DWP/JCP security to implement an electronic solution, however at that time transfers were in their infancy and there was no affordable viable option available
- Sharing information securely was an important aspect of the partnership. It was brought into sharp focus when the general tightening of procedures happened after a serious failure within HMRC.
- By the time the programme was handed over to live running it was not possible to justify the financial investment in a long term national solution. The courier solution was expensive and not ideal but was necessary under DWP security standards

### **Premises**

#### **NHS summary**

Securing office bases and clinical premises has sometimes been complicated and expensive. Because of the uncertainty over continued funding for CMP, NHS trusts were cautious about entering to lease arrangements. Despite this, issues such as lone working have been well-managed by CMPs, and serious incidents have been avoided by assessment of premises.

Using JCP premises for clinical assessments was useful, but was not always possible. For example demand for JCP office space increased in the recession. JCP agreed to fund CMP for additional external premises, but these were sometimes difficult to acquire.

#### **Some local Jobcentre Plus views**

## The Condition Management Programme: Lessons Learned

- Whilst every effort was made to accommodate CMP interviews in Jobcentres, the economic downturn and increase in JSA claims led to, in some Jobcentres, withdrawal of that facility, leading to increased accommodation costs.
- A lot of work was undertaken to establish co-located working arrangements, predominately with CMP colleagues working out of Jobcentres. The reduction of available estate has been problematic in continuing to accommodate CMP staff, however this has led to some innovative approaches and collaborative working e.g. JCP staff being collocated with CMP staff in NHS leased premises.

### **National Jobcentre Plus Views**

- Agree with NHS summary that the uncertainty over future funding created accommodation issues re extending leases that would not have been issues had a clear end date been known
- The economic downturn did create some problems and innovative solutions, such as a mobile unit had to be approved. This was expensive but because by that time no decision had been made about future funding, longer term solutions were not possible

### **Staffing**

#### **NHS summary**

The short-term nature of funding has often created difficulties in recruiting staff. Maintaining short term contracts has not been possible as employment law converts these into permanent staffing contracts over time. Locum staffing has been necessary and useful in some circumstances, but has not been appropriate in all circumstances.

The broad range of clinical skills used has been central to the effectiveness of the programme. Staff have pooled their knowledge, while making their own specialist contribution. They feel they have had good access to training, and that CMP has expanded their perspectives.

#### **Some local Jobcentre Plus views**

- Excellent mix of skills from previous roles of practitioners leading to sharing of knowledge/expertise, to the benefit of customers.
- NHS Recruitment processes could not deliver recruits quickly, reliance on Locum staff to bridge the gap led to significant additional expense.
- JCP Advisers all trained as Pathways Advisers.

### **National Jobcentre Plus Views**

- The quality of IBPA training was highly thought of at the beginning of the programme, but as we moved towards the end of the programme and Jobcentres experienced resource pressures fewer advisers were given the opportunity to complete the whole routeway.
- There was no feedback to indicate that Jobcentres were ever under resourced with IBPAs
- CMPS and districts managed the issue of CMP recruitment locally with very little need for national involvement

### **Clinical Governance & Effectiveness**

#### **NHS summary only**

Evidence-based processes were central to the effectiveness and credibility of the programmes. Standardised assessment tools were widely used (eg COPM, CORE) but each programme used a different set of tools. CMP drew on a large body of existing NHS expertise, which was not only adapted to the specific needs of the service, but also developed. Some programmes found that delivering programmes using NHS clinicians achieved better engagement and completion rates than externally contracted groups.

Non-medical settings were felt to be helpful, but using qualified clinical staff was essential to the service. This did not rule out a skill mixing approach. As well as lower-graded employed staff, some programmes made good use of volunteers, particularly people who had been through the programme themselves.

Additional training was needed to enable staff to carry out the breadth of their roles. For example CBT and Motivational Interview training was found to be really helpful in achieving clinical and employment outcomes.

A Case Management approach was universally adopted because it was found to be effective. This allowed for individual care plans and support, coupled with customers' engagement in group activities. It also allowed for liaison with JCP advisers, GPs and other health services.

NHS individual views:

:

CMP has led to change of practice within several other areas and services. eg. physio assessments now routinely cover employment status / IAPT has ex-CMP practitioners redeployed into their Employment Support co-ordinators / the Trusts Occupational health service has been taken in-house and remodelled as a bio psychosocial holistic model of care, promoting proactive support self care, and providing training in the areas of sickness absence management and stress awareness and management for staff. It is with several ex-CMP staff - so the learning from CMP has definitely had positive impacts here.

For me, both personally and as a manager, my time implementing the CMP programme was the most positive part of my career and I am in no doubt that we made a huge impact on hundreds (thousands) of peoples lives. The quote that CMP was life changing was a frequently heard response from customers.

## **Evaluation**

### **NHS summary**

It is widely felt that a national process should have been in place from the beginning to evaluate the effectiveness of the programme. Local evaluations have shown both good clinical and employment outcomes, but have perhaps lacked the authority that national evaluation, based on standard administrative data, would have had. The roll out of the programme was based on un-evaluated pilots. Within CMP we feel that the evidence used to withdraw the funding to Pathways was perhaps selectively interpreted. Large scale local evaluations, clinical outcome analysis and local anecdotal evidence make us believe that CMP had major positive effects, including reduced attendance at GP surgeries, reduced used of medication, increased levels of activity and better social integration, as well as return to work. Many CMP participants have said it has 'given them their life back'

NHS individual views:

CMP was judged unfairly on work outcomes, as described in the paper, and not on moving people nearer to the world of work as was our remit. This is a long term outcome and required a longitudinal study. I still meet ex-customers now from time to time, who report returning to work recently (even in this difficult economic climate) after having completed CMP 4,5,6 years ago and attributing it to their new way of looking at their health

CMP managers felt that the continuous administrative assessment of employment outcomes would have helped to assess the effectiveness of CMP in

employment terms. Anecdotal evidence and local evaluation seemed to indicate that significant numbers of service users were entering employment, though the later national studies did not reflect this. Further examination of the difference between those national studies which showed a positive effect, and those that did not would have been welcomed

### **Some Local Jobcentre Plus views**

- Programme seems to have been latterly judged on job outcomes and we appear to have lost sight of what CMP was introduced to deliver i.e. addressing customer's health barriers aiming to move them closer to the labour market.
- Locally, PtW Team maintained tracking of customers completing the programme which enabled vital MI about movement into work following CMP to be established. In Merseyside 18% of customers that completed CMP, left IB/ESA and went into work (up to 40% before economic downturn). This was a success factor that should have been monitored nationally.
- "Evaluation measures" should be agreed at the outset. The programme was set up to address customer barriers and move them closer to the labour market. There was no agreed measure of this activity/outcome. There should have been employment outcomes, value for money and cost benefits established from the outset.

### **National Jobcentre Plus views**

It was not possible to disaggregate the effectiveness of CMP from other interventions, within or outside the JCP PtW led Choices package, that the customers was engaging with to conclusively attribute job outcomes directly to CMP

### **Future Opportunities to Exploit CMP learning**

#### **NHS summary**

CMP has been at the cutting edge in the used of enlightened and evidence based approaches. Knowledge has been drawn from best NHS practice, applied in a new context, with major sharing across professions, localities and agencies. This has created improved levels of understanding. We hope that the wider NHS will take on some of this learning which includes:

- the central use of bio-psycho-social approaches particularly to physical health conditions

## The Condition Management Programme: Lessons Learned

- the use of physical activity for mental health difficulties
- the use of physical activity for social engagement and integration
- the use of confidence building groups, based on psycho-educational approaches
- The use of motivational approaches, based on research evidence and clinical expertise
- The use of case management, coupled with group and individual intervention.
- The use of outcome focused, rather than symptom focused approaches.
- The use of collaborative personalised care plans.

Potential areas for using this knowledge include

- the self-management of long-term condition
- the promotion of healthy lifestyles
- information on prescription approaches and personalised care plan approaches
- the integration of employment into clinical services, particularly IAPT and pain management services.
- the management of sickness absence, not only in the wider population, but also within the NHS' own employees.

### **JCP National views**

This model of partnership working between JCP & NHS is unlikely to be reinstated at a national level now national provision is being delivered under the Work Programme contract. However there may be limited opportunities for JCP districts to commission very small scale Health Related Support from the NHS through the Flexible Support Fund.

Work Programme lead providers could commission the NHS to deliver HRS within the Work Programme. This would be a different contractual arrangement so the partnership experience summarise here are unlikely to be relevant to that scenario but the clinical lessons would be invaluable

The partnership issues however could transfer to other potential cross government initiatives where one department is commissioned by another to deliver a service. The lessons learned from CMP could help in this regard.

**Annex 2**

**Case Studies**

[Carol's journey through the Condition Management Programme](#)

[George's journey through the Condition Management Programme](#)

[Case Studies leaflet](#)