Case Study 1: Pathways To Work: Condition Management Programme

Getting Collaboration to Work in Wales

Lessons from the NHS and Partners
Case Study 1:
Pathways To Work: Condition Management Programme

“We know we are helping people on the ground – preventing them from getting in a rut – and to hear the people who have been on the Programme speak, lifts my heart”
Lessons for Practice and Learning

This Case Study is an example of a project that makes the links between health and work – it is firmly in the ‘well being’ arena and involves a partnership between the health sector and Job Centre Plus. At the time of this research, the Condition Management Programme (CMP) was considered by local stakeholders to be successful, and the process of collaboration, largely effective. The reasons for this can be summarised as:

- Having a CLEAR FOCUS involving an appealing vision of making a difference to a vulnerable group
- A national prescription but allowance for local INTERPRETATION AND FLEXIBILITY
- Location within a fertile institutional context and CULTURE OF COLLABORATION
- DEDICATED PROJECT MANAGER and assistant
- Substantial NEW RESOURCES guaranteed over a significant timescale (3+years)
- EFFECTIVE STEERING GROUP with the right people at the right level; consistent membership and attendance; no obvious exclusions; good communication and servicing
- Effective individual and CONNECTED LEADERSHIP from the Local Health Board; Chair of Steering Group; Project Manager; clinical leader
- CONTINUOUS LEARNING from: the experience of pilot projects; good practice and networking amongst other projects; in-built evaluation and customer feedback
- POLICY INTEGRATION between formulation and delivery
- IMPLEMENTATION STRUCTURE: establishment of a Delivery Team
- QUICK WIN: immediate successful outcomes, and ‘something in it for everyone’
- CLEAR OUTCOME FRAMEWORK
- Local EXTERNAL EVALUATION linked to national evaluation
Background

National Programme

Pathways to Work is a national welfare reform programme which aims to provide a single gateway to financial, employment and health support for people claiming incapacity benefits. A key principle of the reforms is that “a substantial proportion of people making claims for incapacity benefits want to work, and are able to do so with the right support; and that doing so would be good for them individually – in terms of finance, and also in terms of their health”\(^1\). Pathways to Work helps to deliver support for people facing health problems or disabilities as well as a co-ordinated approach to tackling the barriers that people face when they are ill or suffer a disability. The programme “combines a balanced package of rights and responsibilities, which aim to target a number of health-related, personal and external barriers in returning to work”.

Amongst the range of services offered under the programme is Condition Management Programme (CMP) support which is provided through the local NHS and enables people to understand and manage their health condition so that they can return to work. CMP is financed and managed in partnership between the Department of Health and Department of Work and Pensions, and is delivered through Jobcentre Plus offices. A national pilot scheme was introduced in the first instance in 2003, but subsequently, the service has been rolled out to over 40% of the UK.

The Programme was a finalist in the ‘Collaborative Working’ category of the first NHS Wales Awards held in 2008.

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Focus and Purpose

CMP is an integral part of the national Pathways to Work Programme, and there is a clear focus and purpose to this programme – the client group is defined by those in receipt of incapacity benefits living in a particular geographical area, it is accessed through a single referral point (Job Centre Plus) and it is an entirely new service that does not duplicate existing provision in this area. A number of people interviewed expressed common understandings of the purpose of CMP and also their personal commitment to making a contribution to the lives of a vulnerable group of people.

However, although the national programme promotes a particular model and there is ‘national steer’, there is certainly a degree of flexibility within its design and delivery to reflect local circumstances and needs, and to take into account customer and practitioner feedback over the course of the programme: “although there is a clear remit and central diktat from DWP, you can localise it and we have the ability to mould it to reflect local circumstances”. For instance, the second CMP course has changed its focus from one-to-one engagement with customers to group-based activities to counter the possibility of over-dependency and to promote group support; unlike a number of other projects, the local team does not employ nurses or cognitive behavioural therapists. Also, the extent to which generic ways of working within a team of specialists is promoted is approached differently amongst the national projects. In the future, changes to welfare benefits may need to be reflected in an extension to those who might benefit from a CMP programme.

Brief Overview

The CMP for the Neath Port Talbot and Swansea areas started in 2006. A project manager and administrative staff are employed directly by the Local Health Board and a team of clinical staff are employed or seconded by Abertawe Bro Morgannwg University NHS Trust. A Steering Group with representatives from a number of different organisations including, Neath Port Talbot County Borough Council, the NHS Trust, Swansea and Neath Port Talbot Local Health Boards, Job Centre Plus, Neath Port Talbot Communities First and Neath Port Talbot Council for Voluntary Service, oversee the work of the Programme which is based around a 12-week Condition Management Course delivered from 27 community venues scattered throughout the Neath Port Talbot and Swansea areas. The course is a cognitive educational programme directed at people with cardio-vascular, mental health and musculo-skeletal problems; it does not involve traditional medical interventions which are delivered through conventional routes. It, therefore, does not duplicate existing services but is in addition to them. Referral rates have been running well above initial planned assumptions (1066 between August 2006 and April 2008) and extra resources have been attracted to the project as a result. Funding is secure until December 2010.
Culture of Collaboration

Interviewees referred frequently to the existence and importance of a culture of partnership working particularly in the Neath Port Talbot area. As well as formal meetings between Chief Executives of the Abertawe Bro Morgannwg University NHS Trust, Neath Port Talbot Local Health Board, Neath Port Talbot County Borough Council and Neath Port Talbot Council for Voluntary Service, respondents claimed that a mature framework of partnership structures including the Local Service Board; Health, Social Care and Well Being Partnership and Children and Young People’s Partnership ensured that collaboration was an accepted aspect of local governance. Critically, respondents also argued that considerable social capital had accumulated between a network of key players enabling joint action to be undertaken in a climate of an understanding of respective individual and organisational roles, responsibilities and ways of working. Key individuals associated with CMP considered themselves to be part of what one respondent referred to as ‘the local partnership mafia’.

Although in some ways, DWP is not immediately recognised as a mainstream partner within the local partnership environment, it argued that it has long been involved in partnership working within economic policy arenas, does have good links with GP surgeries, makes a considerable effort to deliver services through community-based options, and is now a member of the Local Service Board.

In an area with a positive history of collaboration across many policy areas, it appears likely that new initiatives should be easier to design and deliver – and the CMP seems to have benefited in this way. Respondents also argued that acceptance of the CMP initiative was helped by the information and communication that was provided at the start, particularly by DWP and the LHB, to local statutory and voluntary agencies about the purposes of the programme – “specifically to allay any fears that it was about forcing people back to work”. The emphasis on communication has continued throughout the life of the Programme to ensure that a variety of organisational, professional and individual interests are kept abreast of progress – including training sessions, seminars with special interest groups and talks to the wider health community and related networks. This process was considered vital to ensure long term success and sustainability.
Governance and Leadership

Steering Group

CMP has been steered by a local partnership group from its inception. The group is drawn from representatives of the Council, Trust, Job Centre Plus, Communities First and Local Health Board. It is not overly large in size and hence considered manageable; it has developed its primary role through different stages – firstly as a development group – drawing up aims, agreeing a way forward, negotiating with different agencies and compiling a strategic plan – currently as a steering group, meeting less regularly (3-monthly) to co-ordinate and monitor the delivery of the service.

It was considered that the ‘right’ people were represented on the group and that attendance had been consistent with few exceptions. One comment was that: “everyone has a good attitude and there is a collaborative spirit”. Interviewees expressed their confidence in their colleagues referring to trusting relationships amongst themselves and an ability to work well together: “it’s a very effective and well functioning group; the people are supportive, fully engaged and see the benefits of the service; nobody seems to be professionally precious and everyone has something to contribute” and “discussions have been open and frank since the start”. The importance of personal relationships were considered to be critical as “they can be the making or breaking of collaborative arrangements”.

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<td>Is it a matter of ‘luck’ who is represented on a particular group and whether they work well together or can representation be designed in to the process?</td>
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Participants claimed that: “unlike some partnerships where you feel totally uncomfortable and you know its not going to work well, the CMP Steering Group is one where you can trust your partners and there are no hidden agendas- trust is where you know that someone is not going to do the dirty on you and set you up for a fall – in this group I’m not afraid to say anything because I know I’m amongst friends” and “the catalyst for conflict in partnerships are people’s personal egos – but this doesn’t happen here”.

Although the Steering Group was considered to be effective, one interviewee reflected that: “we’ve had our arguments – not many though – but we have resolved them – most of them have been about approach because people come with different perspectives grounded in different models – medical, social and voluntary sector – but we’ve all rubbed each other’s edges off”. Another commented that there needed to be considerable discussion and communication at the start because of the unfamiliarity of key partners – health and Job Centre plus.
Hence: “there was a degree of learning at the start – why are we here, what do we each want- but the coming together was a nice process – it could have easily been derailed if each partner stuck to a medical or social model rather than seeing it in its broader context – it’s not about pills and exercises”. One view put forward was that understanding might have been easier to reach in the CMP because the Occupational Therapists were less likely to be dogmatic about the medical model and intrinsically more sympathetic to the social model of health care. The vitality of the group was identified by members as being partly the result of its success in being associated with a project that has moved rapidly along the policy cycle from design to delivery to making a difference to people’s lives.

**Leadership For Collaboration**

Respondents considered the effectiveness of the individual and collective leadership of the CMP to be a key element in its operation. This leadership can be described as multi-level and connected, consisting of four sources as illustrated in Figure 1. Strategic leadership is provided through the LHB via the Nurse Director: “she is a passionate champion of the project, believes in its aims and the innovative manner in which it demonstrates the principles of the ‘well being agenda’ – making connections between health and work – and ensures that the project is supported by key agencies both through formal channels and informal personal networks”.

**Figure 1: Sources of Leadership for Collaboration**
What is clearly apparent is that this person, together with the Programme Manager and Chair of the Steering Group have personal stakes in the success of the project – they live in the area, are driven by a public service ethos and gain personal satisfaction from delivering benefits to vulnerable people in their communities. The Chair of the Steering Group is a representative from the voluntary sector in Neath Port Talbot and according to respondents brings experience, credibility and effective chairing skills for partnership groups: “the chair is very effective; she listens to all contributions, and is trusted as a safe pair of hands” and “meetings are inclusive – there is a lot of discussion – they can be longer than statutory sector ones sometimes but in the circumstances this is what is needed”. Her credibility is both a reflection of the legitimacy with which the voluntary sector has earned over a number of years through its partnership work particularly with the Council, LHB and Trust, and also the personal network she has developed with senior people – “she knows everybody”.

**Discussion Point**

Does the voluntary sector face particular challenges in participating in partnerships? Involvement can bring benefits in being able to network and lever resource, but it can also bring problems in being ‘too close’ to the statutory sector.

Nevertheless, the voluntary sector is seen as an important source of contact and representation with citizens and service users which is particularly relevant in the CMP programme. The Chair has “always worked closely with Job Centre Plus over the years – it was a local provider under the New Deal programme and demonstrated its ability to organise and deliver programmes effectively”.

Leadership for Collaboration: A Personal Reflection  
(Mrs Gaynor Richards) – Chair Of Steering Group

"Leadership in CCM comes from different sources – it’s about recognising other people’s skills and allowing them to prosper – you need to know what your boundaries are and balance the governance and management roles. Leadership is about understanding the remit of the group and trusting and allowing the managers to manage; I promote a collaborative approach to a shared agenda; it is not a directive role – it involves a balance between setting an agenda and sharing it; setting it together instils a greater sense of ownership and commitment; it is important to promote mutual respect amongst partnership members and an open process to allow full stakeholder involvement throughout the different stages of the partnership process”

"It’s been such a good group to work with – it’s made life easy for me – some of us were used to working together but we needed to listen to everyone’s views – everyone has something to offer and people have been prepared to listen to each other and to work together on behalf of a very vulnerable group – their stories re-motivates us”

“The more confident you are in your own expertise and experience – the more you are comfortable working in partnership – you can accept and defend challenges to your views and opinions – and know that they are not personal”.

"I work closely with the project manager and nursing director – we talk on an informal basis and ‘have lunch’ “

"My independence is important – what I bring is my connections and networks to the project – I’ve worked very hard to build these up and sustain good personal relationships – however, I’m not afraid to challenge – I find it very frustrating when I see other agencies being nice to each other around tables, especially when you know there are real issues – people play this game around partnership tables then have different discussions outside the room – we don’t do that in CCM”.

Steering Group meetings were considered to be appropriately chaired using a style that was both inclusive and facilitative but with an edge that ensured that there was clarity around what needed to be done and by whom. Meetings were reported to be convivial and generally consensual, and in the opinion of one member: “some marginal people around the table still come to meetings, so they obviously remain interested”. One observation of the chair was that: “she works well with the Project Manager; is task-orientated; keeps us on track; is inclusive and manages time well”, another that: she is very skilful and task-orientated; she has a facilitative style and is well connected with senior people in other organisations”, and yet another observation that: “I have total respect for her – she has worked in this area for many years and has credibility – she works closely with the statutory sector and has good strategic links – and she is very good at challenging”.

A third expression of leadership is undertaken at Project Manager level. The Programme Manager is the person most directly involved in shaping and managing the project and also has budget and operational management responsibilities. The post was acknowledged to be challenging requiring commitment, enthusiasm, an ability to work at different levels, strategic management skills, effective negotiation skills, political astuteness, networking ability and an ability to deliver clear benefits to people. The current Programme Manager was a previous employee of DWP and brings both knowledge of the culture and working of that organisation and a close personal network of former colleagues to the work of CMP. The Programme manager: “is a good facilitator – does not make decisions without involving others – works well with the clinical leader with whom she has an open and challenging relationship – and concentrates on building a strong team”. Team building exercises have been undertaken including some with Job Centre Plus advisors, planning/feedback sessions are organised after each training cohort and a social network amongst team members has developed. There was a broad consensus amongst the Steering Group members that the Programme Manager had played a key role in the development and leadership of the project particularly through the promotion of a shared value system based on “openness, transparency, honesty and integrity” and through a “dogmatic approach to getting the systems in place and making them work”. Not being hampered by any ‘professional baggage or culture’ was considered to be an important attribute in her role.

The last element of CMP leadership is the clinical leadership demonstrated by the Clinical Team lead. The lead has responsibility for designing and delivering a programme that is professionally robust and meets the needs of the client group, and leading a multi-disciplinary team of 10 practitioners. The team leader is managerially accountable to the Project Manager but professionally accountable to the Head of OT in the Trust. A distinction between managerial and professional accountabilities has been put in place for the physiotherapists but, in the case of OT practitioners, both are undertaken by the Team Leader because of his professional status in this area of expertise.
Clinical leadership involves: “developing a sense of what the service should look like, leading it and moulding it; communicating it to the rest of the team; it involves listening and giving feedback and growing the service in the future; it is about being open and transparent and not being afraid of making mistakes; it is encouraging staff to be self-managing and respecting people in general”.

Communication was considered to be fundamental together with a focus on the ‘customer’ as the starting point and root of service design and delivery. The Clinical Team leader faces the challenges of building a team from a set of practitioners: “who have stepped outside their traditional models of working – who want to do things differently outside their traditional constraints – are attracted by a new project and are prepared to take risks”. He acknowledges that he faces the challenge of accommodating different models of health – medical and social – although in his experience OT practitioners are generally sympathetic to the social model and conceive ‘health’ in a more open fashion to other medical professions.

The risk of professional isolation or a termination of the project has been recognised from the start and most staff retain NHS Trust terms and conditions of employment and are recruited on a secondment basis.

Respondents argued that a key skill was an ability to learn particularly about the characteristics and workings of different agencies – to understand local institutional arrangements, how they fitted together and how individuals within them saw the world and the pressures they faced on a regular working basis. The interface between the CMP team and Job Centre Plus advisors is especially important – access to the Programme is only possible through Incapacity Benefit Personal Advisors (IBPA) and these people act as ‘gatekeepers’. A short period of training (2/3 weeks) and the use of a ‘screening tool’ are designed to limit the amount of discretionary action and maximise referrals to the Programme. Also, IBPA staff are: “in cases of uncertainty, to refer clients to the CMP team anyway so that a professional judgement can be made by the team on medical grounds”. So, the relationships between Job Centre Plus staff and the CMP team are critical to the smooth running and effectiveness of the Programme – this relationship is maintained through regular contact and communication at a practitioner level and between the Project Manager and the Pathways to Work Support Manager in DWP.

The relationship between the Project Leader and Clinical Leader was also considered to be important – the former being primarily responsible for the overall management of the project, and the latter being focused on delivery. The clinical leader considered that: “the project leader allows him considerable scope and flexibility; is generally ‘hands-off’ and provides an open canvass to develop the service but in consultation with her; is always there for support; can be very challenging if things are not working and open to ‘verbal sparring’”. 
An Integrated Policy Process

Design to Delivery

A key feature of CMP has been its ability to move rapidly from a design and planning stage through to delivery on the ground. This has involved the development of a coherent and planned implementation structure to convert intentions into action, an acute appreciation of who does what and when, and effective project management arrangements. The management of money and people are central to this process. In the case of CMP, finance has been provided by DWP to the LHB on the basis of a funding arrangement, and the appointment of a team of staff is the product of a series of careful negotiations with the Trust. Key members of the Steering Group have played their part in ‘making things happen’ in their respective organisations, and the supportive nature of the Trust and their approach to risk was considered to be particularly invaluable especially in relation to the flexibility involved in seconding staff, and the provision of professional support.

The programme itself has needed to be shaped by the CMP team in consultation with DWP and currently involves delivery in around 27 different community venues. New policies, procedures, forms and systems have been formulated to support the delivery and monitoring of the Programme.

The Steering Group reported that it has gained considerable satisfaction from being able to design and deliver a successful programme and the confidence to work together to secure its sustainability in the future.
Delivery to Outcomes

In addition to being able to move from design to delivery, CMP has been able to complete the policy cycle by achieving discernable outcomes. In terms of throughput, referrals have exceeded planned assumptions by 10% (the only area in the UK to do so) and extra resources have been drawn down from DWP. Customer feedback has been positive as evidenced in the ‘stories’ of a number of people whose lives have been improved as a result of participating in the Programme including some people who have returned to part and full-time working and others whose self-belief and self-confidence has risen. The effect of this ‘success’ and “the powerful boost of patient stories” has provided a great fillip to the Steering Group and CMP team and reinforced their commitment to achieving the aims of the Programme – “all those tears and tantrums and difficult discussions have been worth it – the stories are so emotional about people’s life changes”. The Programme is the subject of a formal and external evaluation, and two research assistants are employed by the CMP team to monitor the progress of the project and develop measures of success that reflect local circumstances.

However, respondents recognised that measuring outcomes was not easy as establishing causal relationships and measuring their impact was highly complex. Currently, “we can’t say how many customers have been helped into work by the CMP programme – we know the numbers in but not the numbers out” (N.B. A one-off evaluation of the progress of a cohort of 250 people engaged in Pathways between January and June 2008 is being undertaken). It is important also to recognise that CMP has different outcomes – not only immediate success in getting people back to work. It can be seen as a ‘stepping stone’ – “can they manage their health condition better? Have they moved onto a re-training scheme? or, Have they moved from incapacity benefit to job seekers allowance?
Evaluation and Continuous Learning

According to respondents, the timing of this project and its inclusion in the roll out of the national programme has enabled it to benefit from the experience of the pilot projects which have been the subject of a national evaluation. Prior to the start of the project, the Programme Manager and others were able to learn from visits to other projects both in Wales and elsewhere in the UK, and a national network of projects provides a fertile environment in which practitioners can share experience and best practice.

Respondents also claimed that the project had benefited from the inclusion of a Programme Manager from another area providing peer support and advice – the Rhondda Cynon Taff/Bridgend project – which was one of the original pilot projects and the first in Wales. This was generally considered to be of great value by the partnership particularly at the early stages during the preparation of the business plan which was used as the basis of the case for funding from DWP. The model for the Steering Group, various systems and structures and other aspects of the design and delivery of the programme has been informed by the experience of the RCT area. Therefore, “the shared experiences, adverts, template for funding arrangements, expert panels, preparing business cases, previous experience, site visits and information sharing” have all contributed to helping the CMP “get up and running quicker than might otherwise have been the case”.

Members of the CMP project were aware of the importance of being able to evidence the impact of the project through evaluation. For example they suggested that the future of the project may well depend on its ability to convince policy makers of the value of the project through robust, policy evaluation demonstrating clear outcomes both in terms of efficiency and effectiveness for customers. As well as a number of national evaluations, the project has commissioned a local evaluation, and measures are continually being devised to ensure sensitive feedback from customers through surveys and individual stories. Aspects of the delivery of the service have been adjusted and amended in the light of these.

Practitioners and managers attracted to the project highlighted the innovative and exciting nature of the programme, and the challenges involved in being able to be associated with a service which both involved working with other professions and agencies, but also brought them into close contact with service users. They claimed that a huge amount of learning had been generated from this exposure to others, through the process of challenging preconceived models and of working together to achieve new models of practice. The service model is not medical or treatment based – it is “cognitive, behavioural and self care as opposed to offering treatment – it does not involve ‘hands-on’ physical interventions which is undertaken by mainstream providers – and it is not about ‘queue-jumping’ – it is about empowering individuals to manage their health more effectively”. The practitioners involved in the project reported that “they find it very exciting to employ their skills in an environment of partnership, a situation that is community-based, and an arena where they feel they can make a difference by getting people back into
Lessons from the NHS and Partners

Commitment and enthusiasm was apparent at both strategic and operational levels and this underscored the importance of attracting people to the project who were ‘enthusiastic’ because this was: “infectious – passion, drive and taking personal responsibility for wanting success are vital – it’s also about taking a degree of risk – of the unknown and of being different”.

**Discussion Point**

How far is learning embedded within key individuals as opposed to being mainstreamed and disseminated into the partner organisations? Some explicit knowledge – in the form of rules, forms, procedures and policies can be formalised – but much of the tacit knowledge accrued by participating individuals can not.

In the course of the research, interviewees raised a number of issues about the CMP service which might usefully be incorporated into future improvements in the Programme:

- The first relates to the limitations of a single gateway into the Programme exclusively through Job Centre Plus. Additional points of referral, for example GP surgeries, might be considered.
- The second issue concerns the role of social care agencies and the feasibility of including social workers as part of the CMP team to make any relevant links to the social care concerns of customers and their impact on health and work.
- Lastly, and perhaps a more fundamental point, is the need to challenge the extent to which this service is integrated or separate from mainstream ‘health provision’ – why is the psychosocial/behavioural element of a person’s health being treated separated from the medical aspects in terms of design and delivery?
The Future

CMP is generally viewed as being successful by partnership members and their sponsoring organisations, but funding is not guaranteed after December 2010. The situation is complicated by the source of funding at a national UK level through the Department of Health and DWP. Devolution of health matters to Welsh Assembly Government and its current lack of formal inclusion in the Programme will need to be addressed. Although exit strategies are written into the original Programme agreements particularly in relation to staff and the costs of redundancy, the continuation of the local Programme will require a concerted effort both in terms of producing a robust evidence base but also a ‘political’ campaign to convince key policy makers of the merits of mainstreaming the provision. The Steering Group is keenly aware of the need to address these issues sooner rather than later, although major health service reorganisation is not likely to be helpful at this critical time.

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