Pathways to work

Qualitative research on the Condition Management Programme

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Policy Studies Institute

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Pathways to Work: Qualitative research on the Condition Management Programme

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List of abbreviations

BA	Benefits Agency
CBT	Cognitive Behavioural Therapy
CMP	Condition Management Programme
CPN	Community Psychiatric Nurse
DoH	Department of Health
DWP	Department for Work and Pensions
FA	Financial Assessor
FCO	First Contact Officer
IBPA	Incapacity Benefit Personal Adviser
IS	Income Support. Income Support is a noncontributory, income-assessed benefit available to people who are not required to work.
LHB	Local Health Board
JPP	Job Preparation Premium
JSA	Jobseeker's Allowance
NDLP	New Deal for Lone Parents
PCA	Personal Capability Assessment
PCT	Primary Care Trust
RTWC	Return to Work Credit
WFI	Work Focused Interview

Summary

In October 2003, based on proposals outlined in the Green Paper 'Pathways to Work: Helping People into Employment' (2002), changes to the claiming requirements and services offered to people making a new or repeat claim for Incapacity Benefit (IB)[1] were introduced on a pilot basis in three Jobcentre Plus districts (an additional four districts became part of the pilot in April 2004). A further 14 districts are joining in phases from October 2005, so that Pathways service will be operating in a third of the country by October 2006.

The main elements of the pilot provision are as follows:

- **New specialist teams** of specially trained **IB Personal Advisers** (IBPAs), as well as Disability Employment Advisers (DEAs) and Work Psychologists, to advise and support people directly.
- New IB customers are required to take part in a **Work Focused Interview (WFI)** with the IBPA eight weeks after their claim[2]; most will then be required to undertake a series of five further mandatory WFIs. Non-attendance can result in deductions from benefit.
- A **Choices package** of interventions offers people a range of provision to support their return to work. The package consists of easier access to existing programmes, such as New Deal for Disabled People (NDDP), Work Preparation and Work-Based Learning for Adults (Training for Work in Scotland). The package also includes new work-focused **Condition Management Programmes (CMP)** developed jointly between Jobcentre Plus and local NHS providers
- A **Return to Work Credit** (RTWC) of £40 per week, payable for a maximum of 52 weeks, is available to those working 16 hours or more, where gross earnings are less than £15,000 a year.

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[1] From February 2005, the Pathways provision was extended on a mandatory basis to some existing customers (those making a new claim in the two years prior to the start of the pilot) in the first seven pilot areas.

[2] This is the case for all claims, and not only in the pilot areas, from October 2005.

- IBPAs have access to an **Advisers' Discretion Fund** (ADF). This currently allows them to make awards of up to £100 per customer to support activities that can improve the likelihood of a person finding or taking up a job.[3]
- Only those identified as having the most severe functional limitations (i.e. Personal Capability Assessment (PCA) exempt) and those identified through a **screening tool** as least likely to need additional help to make a return to work, are not required to attend the series of mandatory WFIs, although these (and all) IB customers can request such interviews on a voluntary basis. All IB customers in the pilot areas have equal, voluntary, access to the Choices package, the RTWC and the ADF.

As described above, the pilot districts have adopted varying models of CMP provision, and it was decided to sample all of these, to explore the full range of experiences to date. The study was, therefore, conducted in all of the first seven Jobcentre Plus districts:

- Renfrewshire, Inverclyde, Argyll and Bute;
- Essex;
- Derbyshire;
- East Lancashire;
- Somerset;
- Bridgend and Rhondda Cynon Taf;
- Gateshead and South Tyneside.

The fieldwork involved depth interviews with CMP practitioners, co-ordinators and managers. The fieldwork took place in summer 2005, when most CMP provision had been open to customers for slightly under a year. Because the focus of the study was on the implementation challenges, rather than customer experiences and outcomes, no customers were interviewed as part of this research. Customer experiences are explored in other reports.

The research includes three areas where an in-house NHS model of provision has been implemented, three where the majority of provision is in-house NHS and one which has adopted a much more mixed model of provision. Some areas following solely or largely in-house models of provision, reported concerns about capacity for the future. All areas with contracted out provision reported quality management issues that needed to be addressed and had made varying degrees of progress towards doing so.

While some practitioners described their caseload as containing a good mixture of mental and physical conditions, others commented that as much as 80 per cent of

[3] Previously £300.

the customers they saw had mental health problems, and this group was generally viewed as harder to help. A number of practitioners commented on the complexity and difficult circumstances of customers' lives.

Practitioners had generally been pleasantly surprised at customers' responses to provision, finding the majority of people they saw to be highly motivated, despite often severe health problems. Few reported customer resistance to what was being offered.

Practitioners reported a full spectrum of progress, from those who made rapid and extensive progress, to those who had moved only a small distance. Improved confidence, self-esteem, physical appearance and stamina were all noted as immediately observable effects of participation. While acknowledging that a return to paid work of over 16 hours was *'the gold standard'* from the point of view of Jobcentre Plus, CMP practitioners themselves also had different outcome measures in mind when working with customers. These included reduced need for medication (e.g. lower doses of painkillers or anti-depressants), increased functioning (e.g. being able to leave the house after tackling agoraphobia) and improved quality of life (e.g. joining a walking group or gym).

Those interviewed had not generally had previous experience of working with Jobcentre Plus, and most CMP practitioners knew little, if anything, about the Pathways to Work pilots before applying for employment, so they did not necessarily begin with a very definite idea of their role within the pilots, or of the inter-agency work that would be involved. They also did not necessarily have a clear sense of how CMP contributed to the overall aims of the pilot; this had tended to develop over time.

A number of CMP practitioners were based within Jobcentre Plus offices. This was seen to have advantages in facilitating informal feedback and contact, and referral levels were noted as having increased where CMP practitioners were located in the same building. CMP practitioners had different experiences of working with IBPAs. Some described close and mutually supportive working relationships, while others rarely saw the PAs who made referrals to them, and felt that PAs had a limited understanding of the purpose and role of CMP.

Most practitioners reported that the referrals they are receiving are broadly appropriate and in line with the numbers initially expected. Some practitioners argued that they would far rather err on the side of being 'inclusive', even if this meant a proportion of unsuitable referrals.

CMP practitioners interviewed, commented that networking with other agencies was a key element of their role. Job brokers were reported as being fairly widely used, mainly for referrals following the completion of CMP. In some districts, CMP practitioners had day-to-day contact with job brokers, while in others this was an area that fell to IBPAs to deal with.

Contact between GPs and CMP was widespread across all pilot areas, but it took different forms. In some areas, there was a formal protocol, with a letter being sent to the GP, with the customer's consent, while in other districts the main form of contact with GPs was outreach sessions held at surgeries. As with GPs, contact with other health professionals was a feature of CMP practitioners' work across all pilot areas but was generally more limited in scope. Most commonly, practitioners were involved in liaising with other professionals in relation to an individual customer.

In addition to contracted-out provision delivered as part of CMP, contact with voluntary sector agencies was occurring in relation to customer referrals, and as a source of voluntary work experience. Contact with employers was reported as being very limited and only a handful of the CMP practitioners interviewed were involved in providing in-work support. Some CMP managers envisaged doing more work with employers in the future, but others were very clear in their view that this was outside the CMP remit.

Both CMP managers and practitioners reported very high levels of job satisfaction and transmitted a real sense of enthusiasm and commitment to the service. The variety offered by the work was highly valued, as was the degree of customer contact involved. Those who had previously been working in NHS settings commented on the increased satisfaction offered by being able to offer preventative health care, allow longer appointment times and provide continuity of care. These were factors which they felt enabled them to address deep-seated issues and problems, rather than simply treating the presenting condition.

Some CMP practitioners had been attracted to the initiative precisely because it represented a development challenge and had not found this daunting, while others had found delivering a completely new service quite stressful and difficult at first.

Interviewees were asked for their thoughts regarding the task facing the next 14 areas, and for specific advice they would offer based on their own experiences. A key point made by several practitioners was the importance of clarity about what is being proposed, both within the CMP team, and in terms of promoting it to outsiders. New areas were advised to develop services based on existing models of good practice, rather than seeking to create something entirely new. A related point, made by those with experience of contracting out provision, was that it was helpful to concentrate on working with a limited number of providers with specialist expertise. Given the time it takes to recruit suitable staff, it was argued that it was vital to start getting people in post as soon as the broad outline of provision had been decided. There was also perceived to be a longer-term need to make CMP more attractive to potential recruits.

Interviewees highlighted the need for appropriate infrastructure and communication protocols to be set up as quickly as possible, to ensure that CMP was effectively networked with Jobcentre Plus and able to work in an efficient and mutually supportive way. Those with contracted out provision felt that the incentive structure for quality control issues needed to be strengthened in some way.

Networking with local agencies was seen as vital to avoid duplication, raise awareness about CMP locally, and ensure that customers had access to appropriate services. The importance of effective marketing of CMP was also emphasised.

The level of resources for CMP was felt to be important. The additional time available for customers, and the fact that services could be tailored to meet individual needs, were seen as key factors in meeting customer needs. There were some concerns that future levels of funding for CMP might be less generous and that this could be detrimental to the development of new services.

Finally, those delivering CMP urged those about to embark on this task to have confidence in their ability to help customers improve their health status and employability.

1 Introduction

1.1 The Incapacity Benefit Reforms – Pathways to Work

In October 2003, based on proposals outlined in the Green Paper 'Pathways to Work: Helping People into Employment' (2002), changes to the claiming process and support offered for Incapacity Benefit (IB)[4] customers were introduced on a pilot basis in three Jobcentre Plus districts (an additional four districts became part of the pilot in April 2004). A further 14 districts are joining in phases from October 2005, and the Pathways service will be operating in a third of the country from October 2006.

The new package is intended to re-focus customers on the prospects of returning to work through the combination of a series of Work Focused Interviews (WFIs) and various associated services and incentives. The main elements of the pilot provision are as follows:

- **New specialist teams** of specially trained **IB Personal Advisers** (IBPAs), as well as Disability Employment Advisers (DEAs) and Work Psychologists, have been set up to advise and support people directly.
- New IB customers making fresh claims are required to take part in a **WFI** with the IBPA eight weeks after their claim (this has now been standardised for all IB customers, not only those in the pilot areas); most will then be required to undertake a series of five further mandatory WFIs at roughly monthly intervals. Non-attendance can result in deductions from benefit (**sanctions**).
- A **Choices package** of interventions offers people a range of provision to support their return to work. The package consists of easier access to existing programmes, such as NDDP, Work Preparation and Work-Based Learning for Adults (Training for Work in Scotland). The package also includes new work-focused **Condition Management Programmes (CMP)** developed jointly between Jobcentre Plus

[4] Includes Income Support with a Disability Premium

and local NHS providers, which started seeing customers in August 2004, and are the subject of this report. These programmes have been designed in response to the main conditions reported by those claiming IB (mental health, musculo-skeletal and cardio-vascular) and adopt a bio-psychosocial model with an emphasis on enabling the customer to better manage their health condition, to improve their quality of life and employability.

- A **Return to Work Credit** (RTWC) of £40 per week payable for a maximum of 52 weeks is available to those returning to or finding new work, of 16 hours or more, where gross earnings are less than £15,000 a year.
- IBPAs have access to an **Advisers' Discretion Fund** (ADF). This allows them to make awards of up to £100 per customer to support activities that can improve the likelihood of a person finding or taking up a job (for example, purchasing new clothes to attend interviews).
- Only those identified as having the most severe functional limitations (i.e. Personal Capability Assessment (PCA) exempt) and those identified through a **screening tool** as least likely to need additional help in making a return to work, are not required to attend mandatory WFIs, although all customers can request such interviews on a voluntary basis. All IB customers in the pilot areas have equal, voluntary, access to the Choices package, the RTWC and the ADF.

From February 2005, the Pathways provision was extended to some existing customers (those making a new claim in the two years prior to the start of the pilot) in the seven original pilot areas. The provision differs from that available to new customers in several respects:

- **contact by telephone** advising of the changes, so that eligible customers are aware of their responsibilities, and the help available in the Pathways service, before they are asked, in writing, to take part in WFIs;
- three **compulsory WFIs**, rather than six;
- in addition to any other incentives, the availability (on a discretionary basis) of a **Job Preparation Premium (JPP)** of £20 per week. This is payable for up to 26 weeks, for those engaged in work-related activity which will support a return to employment.

1.2 Overview of the evaluation

The key objective of the evaluation is to establish whether (and by how much) the pilot helps IB customers move towards the labour market and into work. In doing so, it will describe and explore underlying processes and factors which account for differing outcomes and experiences of the pilots. The evaluation includes research with IB customers, staff and providers; qualitative and quantitative evaluations of process and outcomes, a net impact analysis and cost-benefit analyses.[5]

1.2.1 An overview of the impact analysis

The impact analysis will estimate the overall impact of the Pathways to Work pilots on a number of outcomes related to different aspects of the labour market (with the primary outcomes of interest being: employment, exit from benefits, earnings, employability and health). In addition, it will estimate the impact of the Choices package, the RTWC and whether the pilot has caused substitution effects. The methodology will be a combination of difference-in-differences, propensity score matching and micro-simulation techniques.

1.2.2 An overview of the quantitative research

The quantitative elements comprise a face-to-face survey and two telephone surveys with customers. A telephone survey to collect information equivalent to that obtained by the screening tool will take place with two cohorts in both pilot and non-pilot areas, before and after the start of the pilot. This survey will provide information from non-pilot areas in order to provide a comparison on which to base an assessment of the impact of the programme. A large scale face-to-face survey will take place over two stages with IB customers. This survey will quantify findings arising from the qualitative research.

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[5] The following reports are already available:

DWP In-house analysis

Incapacity Benefit reforms – Pathways to Work Pilots performance and analysis, DWP Working Paper No. 26, January 2006.

Commissioned Reports

Incapacity Benefit Reforms – the Personal Adviser Role & Practices: Stage Two, National Centre for Social Research, DWP Report No. 268, Sept 2005.

IB Reforms Pilot: Findings from a longitudinal panel of clients, Social Policy Research Unit, DWP Report No. 259, July 2005.

Incapacity Benefit Reforms – The Personal Adviser Role & Practices, National Centre for Social Research, DWP Report No. 212, November 2004.

Incapacity Benefit Reforms - Early findings from qualitative research, National Centre for Social Research, DWP Report No. 202, September 2004.

Available from http://www.dwp.gov.uk/asd/

1.2.3 An overview of the cost-benefit analyses

The cost-benefit analyses will indicate whether the monetary benefits from pilot measures outweigh their monetary costs from a societal point of view and, hence, whether they are economically efficient. It will also indicate whether the pilot measures improve the wellbeing of those who receive the services provided and what the net effects of the measures are on the government's budget. Thus, it will provide information critical to any decisions concerning whether to introduce some or all of the interventions in other Jobcentre Plus districts.

1.2.4 An overview of the qualitative research

The qualitative evaluation has several components exploring staff, provider and customer perspectives on the new pilots. The individual components are described below. The research involves both focus groups and one-to-one depth interviews; it began in October 2003 and will continue through to December 2006.

- **Site visits** were used to familiarise research staff with the implementation of the pilots in each district, to identify differences in the ways the pilots are being delivered across the pilot districts, and to establish contacts and working relationships with the staff involved. For the early sites these took place in late 2003/early 2004. In the later areas, these visits happened in May 2004 shortly after the 'go-live' date of 5 April 2004.
- **Six early focus groups,** the subject of a previous report, **with IBPAs and IB customers** were conducted in early March in each of the first three pilot areas[6].
- A **longitudinal panel study with IB customers** began in April 2004 in the first three pilot areas[7]. Two staggered subsequent waves are also being conducted, covering all seven pilot districts. The panel is exploring customers' experiences of IB pilots in a series of interviews. An initial (face-to-face) interview is being followed up (by telephone) after three months and then again after another six months.
- A **series of short, self-contained focused studies,** designed to provide rapid feedback to staff and policy makers. These studies are exploring the PA roles and practices[8], CMP, In-Work Support (IWS), RTWC, and various aspects of the extension of the pilots to existing customers. This report is the first to deal specifically with CMP.

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[6] Dickens, S., Mowlam, A. and Woodfield, K. (2004), Incapacity Benefit Reforms – early findings from qualitative research.

[7] See Corden, A., Nice, K. and Sainsbury, R. (2005) IB Reforms: Findings from a longitudinal panel of clients.

[8] Knight, T., Dickens, S., Mitchell, M. and Woodfield, K. (2005) Incapacity Benefit reforms – the Personal Adviser roles and practices: Stage two.

- The **experiences of existing customers** are to be explored in a number of ways, including new studies specific to the experiences of existing customers (e.g. early experiences study, JPP focused study), and by incorporating existing customers into the samples for other planned elements of the evaluation (e.g. RTWC focused study).

The report consists of a further five chapters: Chapter 2 briefly describes the methodology for the study. Chapter 3 gives an outline of CMP provision across the pilot districts. Chapter 4 discusses CMP practitioners' and managers' perspectives on working with customers, while Chapter 5 explores their experiences of working with other agencies. Chapter 6 draws together some overall views on the early operation of CMP, and identifies some emerging conclusions and their implications.

2 Research design and methodology

2.1 Background and research questions

The Condition Management Programme (CMP) provision was drawn up jointly between the Department of Health (DH) and Department for Work and Pensions (DWP) as part of the Pathways to Work pilot. It is work-focused and has been designed in response to the three main conditions reported by those claiming Incapacity Benefit (IB) – mental health issues, and cardio-vascular and musculo-skeletal problems. As Chapter 3 discusses, some areas have delivered generic provision, while others have created specific modules for certain conditions, but there has been a movement towards more generic provision over time.

Based on a bio-psychosocial model of health and illness, the aim of CMP is to go beyond simple medical interventions and tackle more deep-seated issues such as anxiety, pain management and lack of confidence. It is intended to be empowering, and is explicitly not about providing 'treatment'. Plans for service delivery were drawn up in each district according to the area's needs profile, and commissioned by Primary Care Trusts[9] (PCTs). Widely varying models of delivery have been adopted, including in-house, full or partly contracted out, and involving a single or multiple PCTs. Key issues identified for the research include:

- To what extent do CMP providers feel part of the Pathways to Work pilots as a whole?
- How are customers responding to CMP provision, and what impact does it have?

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[9] In Wales, these are Local Health Boards (LHBs). For reasons of confidentiality, these have not been distinguished in the text, but all references to PCTs in the report should be taken to include LHBs.

- How do CMP providers work with customers, and to what degree do they incorporate a work focus?
- The relationship with Jobcentre Plus and other local agencies – how is this developing and what issues have arisen along the way?
- What lessons can new pilot areas learn from the experiences of the first CMP providers?

2.2 Research design

As described above, the pilot districts have adopted varying models of CMP provision, and it was decided to sample all of these, to explore the full range of experiences to date. The study was, therefore, conducted in all the first seven Jobcentre Plus districts:

- Renfrewshire, Inverclyde, Argyll and Bute;
- Essex;
- Derbyshire;
- East Lancashire;
- Somerset;
- Bridgend and Rhondda Cynon Taf;
- Gateshead and South Tyneside.

The fieldwork involved 37 depth interviews (most face-to-face, although some were conducted by telephone) with CMP practitioners, co-ordinators and managers across the pilot areas. The fieldwork took place in summer 2005, when most CMP provision had been open to customers for slightly under a year. Because the focus of the study was on the implementation challenges, rather than customer experiences and outcomes, no customers were interviewed as part of this research. Their experiences of CMP are reported in other studies, for instance in the longitudinal panel, and are cross-referenced as appropriate in this report.

2.3 Analysis and interpretation

Interviews and discussion groups were tape-recorded and transcribed for analysis.

The data for this study was analysed systematically using 'framework'. This is a qualitative analysis method, developed by the National Centre for Social Research, which uses a thematic approach to classify and interpret qualitative research data, using a series of charts relating to different thematic issues. Data is summarised into the appropriate cells with the context retained and its location in the transcript noted, allowing the analyst to return to a transcript to explore a point in more detail

or to extract text for verbatim quotation. The charts allow the full pattern of an individual's attitudes and behaviour to be reviewed. They also display the range of views or behaviours described by participants, and allow the accounts of different participants, or groups of participants, to be compared and contrasted. The method of analysis allowed us to draw comparisons between the perspectives of different CMP managers and practitioners.

3 Organisation of the Condition Management Programme across Jobcentre Plus districts

3.1 Introduction

As noted in chapter 2, the research covers all seven early pilot areas. It includes three areas where an in-house NHS model of provision has been implemented (areas 1, 2, and 3) three areas where the majority of provision is in-house NHS (areas 4, 5 and 7) and one area which has adopted a much more mixed model of provision (area 6). The chapter begins with an overview of models of the Condition Management Programme (CMP) organisation across each area, drawing out the rationale for the approach adopted. It then moves on to consider staffing issues, gaps in provision and challenges before exploring provider quality management in contracted out services.

3.2 Models of the Condition Management Programme organisation and their rationale

This section provides a brief overview of the CMP provision across the seven pilot areas[10]. It outlines the nature of CMP organisation and Primary Care Trust (PCT) involvement, the kind of the geographical area being covered, the main features of the CMP provision, type of provider staffing and notable characteristics of the client groups being worked with, Table 3.1. presents this key information in summary form.

[10] Note that these are not presented in the order listed in Chapter 1.

Table 3.1 Summary of CMP provision

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7
CMP organisation	In-house Single PCT	In-house 2 PCTs	In-house 4 PCTs	Mixed, mostly in-house 8 PCTs	Mixed, mostly in-house 2 PCTs	Mixed, 13 PCTs	Mixed, mostly in-house
Nature of area covered	Urban and rural	Urban	Rural	Urban and rural	Urban and rural	Urban and rural	Urban and rural
Main provision	One to one cognitive behavioural therapy	One to one work, needs-led, client centred	Group cognitive behavioural therapy	Group sessions	One to one sessions	Group sessions	Group and one to one work
Staffing	Generic CMP practitioners, with clinical background	Clinical specialists	Clinical specialists	Clinical specialists	Clinical specialists	Mostly generic CMP practitioners and clinical specialists	Generic CMP practitioners, some with clinical background
Notable client group characteristics	High rates of Mental Health problems and substance abuse	Wide range of conditions, often multiple impairments	Range of impairment, no typical customer though self esteem and confidence problems evident	High rates of Mental Health problems Many young people	Musculo-skeletal and Mental Health problems	High rates of Mental Health problems	Low take-up by ethnic minorities Many young people

3.2.1 Area 1

In area 1, an in-house NHS model of provision has been adopted, involving a single PCT covering a very wide geographical area, which encompasses both large urban centres and isolated rural settlements. This PCT has changed several times in recent years, with the merger of adjoining authorities, and was set to do so again at the time of fieldwork. In addition to there being a shortage of suitable non-NHS providers locally, the decision to adopt an in-house model of delivery was explicitly informed by a desire to maintain centralised control. Providers have an NHS base which is their administrative headquarters and provides an actual base for some CMP staff; others are based within Jobcentre Plus offices.

Much of the work with customers involves counselling on a one-to-one basis, with frequent use of home visits, but there are also some group modules available. All staff have been recruited as generic CMP practitioners, regardless of their clinical specialism (the team includes nurses, occupational therapists and physiotherapists), and all provision is based on cognitive behavioural therapy (CBT) techniques. Mental health problems account for over half of all Incapacity Benefit (IB) claims in this area, one reason for the strong emphasis on CBT, and these are often aggravated by substance misuse issues.

3.2.2 Area 2

Like area 1, area 2 has an in-house NHS model of provision, covering PCTs across two urban areas. The approach to CMP provision in this area was described as being aimed at *'empowering'* people to take control over their lives, a *'mentoring'* rather than a *'therapeutic'* orientation to support. Programme participants are encouraged to think about all aspects of their lives, not just health, so that they made their own decisions about the best way forward. The co-ordinator emphasises the desire from the outset for a *'needs-led, client-centred'* approach and perceives this goal to have been achieved. Provision is largely delivered on a one-to-one basis, but group work is also available and undertaken.

An early task for the co-ordinator was to engage with a range of stakeholders in order to get them to *'buy in'* to CMP. This involved a great deal of liaising with NHS professionals and her professional NHS background was felt to have facilitated this. The CMP team now comprises a range of clinical specialists including occupational therapists, physiotherapists, nurses and an occupational psychologist. Customers have a wide range of conditions, which are multiple. They also raise many other relevant issues, for example, relating to family, relationships and financial difficulties that are relevant.

3.2.3 Area 3

Area 3 is a rural area with an in-house model of NHS provision. There are four PCTs in the area. All four PCTs are involved in CMP, but one has taken the lead. Area 3 has been trying to get CMP ingrained as a way of thinking within the NHS, rather than just a programme that the Department for Work and Pensions (DWP) offers for IB

claimants that appears distant from core NHS activity. Consequently, CMP provision in the area is joint-funded with the NHS and the integrated nature of the service was stressed by the area co-ordinator:

> *'...this is an integrated service...I mean the way we've done it is that two out of three* [pain management] *sessions are NHS-funded and one is CMP-funded, and the admin is CMP-funded.'*

A group modular approach has been adopted in programme delivery. Rather than being based on efficacy, the group approach was based on the *'cost driven'* pragmatics of low numbers of referrals in a rural area. One manager presented this as being a necessary compromise. However, the manager also emphasised that there is an absence of research to indicate whether one-to-one provision is better than a group-based approach. Most CMP staff came from the NHS and are clinical specialists. The CMP team of 22 includes physiotherapists, occupational health nurses, cardiac nurses, health psychologists, assistant psychologists, mental health nurses and community nurses. Customer referrals reflect a range of impairment, though one practitioner reports that the typical customer has issues with self-esteem and confidence problems.

3.2.4 Area 4

The majority of area 4's CMP provision is in-house, but one component, relating to mental health, has been contracted out, so technically it has a mixed model of provision. Area 4 encompasses both rural and urban areas. Four of the eight PCTs in the area are involved in delivering CMP. Area 4 follows a condition-specific model of CMP provision, rather than a generic case management model. It was felt that because most people opt to call on the support of someone most able to understand their condition and start advising them, the specific service model would deliver the quickest, most efficient and most effective service.

The CMP provides a variety of group work for people with mental health needs and cardiovascular conditions. There is also a smaller individual cognitive behavioural therapy component. All assessments and therapy are carried out by registered qualified CBT therapists. Staff tend to be trained clinicians. Seconded staff have been drawn into the CMP programme as development partners. While briefed on their new roles at the outset they have been required to develop these roles as CMP bedded down. At the time of fieldwork there was a high proportion of clients with mental health problems and a very low number of cardiovascular clients.

3.2.5 Area 5

Area 5, which covers both urban and rural localities, has adopted a mixed model of provision working with customers who have musculoskeletal and mental health conditions. Two PCTs are involved in CMP, one taking the lead. While the provision is predominantly in-house, part of the programme, physiotherapy for those with musculoskeletal conditions, is contracted out to a private sector company. A key criterion in enlisting organisations to deliver CMP services was their ability to provide

equitable delivery across the district and to all locations, to individuals living within and beyond the district. To avoid duplication of health services a lot of preliminary *'mapping of local services'* needed to be done to ensure the CMP did not *'create any conflict with any services'* and that they weren't *'reinventing the wheel'* or *'duplicating provision'*.

The core CMP provision involves one-to-one work reflecting the importance of ensuring that provision is 'needs led' rather than service led. While group work is used in pain management courses, even here there is an emphasis on responsiveness to individual needs.

CMP is delivered by a multi-disciplinary team, with a pivotal role for occupational therapists in undertaking initial assessments. Occupational therapists are seconded to the private sector company, from a local acute Trust. Mental health staff are employed directly by the PCTs. The decision to organise provision in this way was based on existing partnerships. The private sector physiotherapist company was already known to the PCT and had a track record of delivering services. There was also an existing relationship with local acute Trusts for the provision of occupational therapists, whose function underpins the whole CMP.

3.2.6 Area 6

A mixed model of CMP organisation has been adopted in area 6, to a much greater extent than in areas 4 and 5. The area comprises urban and rural localities, the former with high population densities. It has 13 PCTs and the lead PCT for the programme works on behalf of the other 12, taking the lead because it has the most capacity. Provision has largely been contracted out to the private and voluntary sectors. Of the ten providers recruited to deliver CMP across the area, just two are from the NHS. The mixed model of provision was stimulated by a range of considerations. These included the area's capacity to provide for a high volume of customers and the anticipation of referrals being skewed to particular urban localities. There was also a desire to give potential participants choice in the type of provision they could access regardless of whether they lived in an urban or rural area. As will be explored in more detail, service level agreements, alongside supplementary measures, form an important part of the regulation of contracts with providers.

All customers see a health assessor, who visits Jobcentre Plus offices, and has a pivotal role in determining subsequent pathways through CMP. Area 6 places a lot of emphasis on group work, across a range of providers, with one to one counselling being provided on a discretionary basis. While core provision is based on vocational rehabilitation with an emphasis on CBT, alternative therapies have also been integrated into the programme, reflecting the aim of providing wider choice of services to access.

Reflecting the high level of involvement of private and voluntary sector providers, staff involved in the delivery of CMP are mostly generic practitioners with clinical specialists being integral to the NHS provision. Customers have a range of impairments, tend to be in their 40s and 50s *'and feel like they're on the scrap heap*'.

The majority have issues of anxiety, low or falling confidence levels and stress. It is estimated that 60 per cent of customers want help getting back to their optimum level of mental health.

3.2.7 Area 7

In area 7, the CMP is being delivered as a mixed model of provision, mostly in-house, but with some contracted in providers. These providers are contracted to deliver group CBT and also exercise on prescription. Area 7 covers three PCTs, one acting as a lead, covering a small and widely distributed population, which encompasses both rural and urban areas, and both affluent and severely deprived local authority districts. In some areas, there is a high proportion of people from ethnic minorities, mostly originating from the Indian subcontinent.

All customers referred by their Incapacity Benefit Personal Adviser (IBPA) have an initial appointment with a case manager, who is a qualified occupational therapist, specialising in vocational rehabilitation, and who acts as a gateway onto the provision. The case manager carries out a health assessment in the Jobcentre and provides advice on the best course of action. The provision includes both group and one to one work and ranges from CBT to salsa dancing classes. Mental health interventions are all based on CBT.

All the CMP staff in this area have been recruited as CMP practitioners regardless of their clinical specialism, and are working outside their 'traditional' professional boundaries, an aspect of the work which many enjoy. Take-up among ethnic minorities has been low, largely owing to ESOL issues. Several practitioners have been struck by the higher than expected number of young people with anxiety and depression.

3.3 Staffing issues

The key staffing issues centred on recruitment of the appropriate range of staff to deliver the CMP, the kinds of adjustments that needed to be made to ensure appropriate capacity as circumstances change and issues around pay differentials.

An early challenge in one area with mostly in-house provision has been staffing complements, including identifying the range of staff needed to provide a service, the skills different professions could bring and how to attract staff in a way that *'didn't drain existing staff pools'*. Setting up a professional steering group to advise on the complements of staff necessary avoided any staffing difficulties. This area has made use of the Jobcentre Plus screening tool and a GP adviser to help decide what types of customers they were likely to see and what staff would be needed, leading to the establishment of an initial core team of practitioners. One CMP manager described a process of managed recruitment which worked in a rather reflexive way after the appointment of an initial core team:

'...(we) worked with that team to start planning and developing the service and to take the initial referrals as they come through and then we'd manage recruitment in stages according to demand...'

Much emphasis was placed on the importance of continually measuring the level of referrals for different conditions and recruiting staff in response to individual and group needs.

One or two pilot areas have needed to reflect on how joining CMP could be made more attractive. One area had found it difficult to recruit staff in a labour market context of high demand for qualified staff. The main selling point used to attract staff has been the availability of development opportunities and the chance for appointees to work in '*something unique*'. The CMP manager felt that the programme was not necessarily attractive to those at the start of their career as it did not present a well-defined career path (although well resourced and with plenty of development opportunities) while for those at more senior levels there may be less incentive to take on such a challenge. This area has been glad to have built in some grade progression for their staff because they have heard that other areas are having problems with this.

Where there were initial problems in recruiting occupational therapists in another area, being able to offer flexible arrangements, with a phased move into full-time work within the programme, had helped get the service up and running. At the time of fieldwork a recruitment exercise was underway; management was feeling short-staffed because referrals had reached almost one-third over the number expected in the first year. For the first recruitment exercise, they were looking for people who understood the bio-psychosocial model of care; that is clinicians who were willing to take their hands off, step back, and let the person empower themselves. While initial advertisements were for physiotherapists and occupational therapists, future adverts will be for practitioners without specifying a specialism. The possibility of NHS secondments to CMP are being explored with a view to CMP knowledge being brought back into the NHS. Of the current CMP team, more than half are practitioners.

Several areas following solely or largely in-house models of provision, reported the need to make accommodations in staffing over time to reflect changing circumstances. One area which experienced no difficulty with initial recruitment of occupational therapists, plans to double the size of its CMP team as workloads rise due to an expected increase in new customers plus the addition of existing customers. However, there are anxieties around there not being the right people in the labour market to fill the posts. In the areas which experienced initial difficulties in recruiting to some posts, co-ordinators were not sure about the reasons for this but speculated that joining CMP was perceived as a big step given that the new posts were only advertised as two year contracts, and that people were unsure how it would contribute to their overall career development.

Issues around pay differentials were raised in three of the seven areas, including reported tensions around people feeling that they were being paid very different amounts for what was essentially the same job. In one area, staff have been recruited using *'traditional pay scales'* within the NHS. While its contracted physiotherapists are paid at agency rates, to date there have been no concerns among staff. There has been staff unrest in another area where clinicians from different backgrounds have moved into generic practitioner roles doing the same job for different rates of pay. As the manager explained:

> *'…it's created quite a bit of unrest really because you've got people doing the same job but the earnings gap is significant really. People who've come in on top of a grade to people who've been recruited at the bottom of the grade and they're doing basically the same role. It has been difficult and when you've got staff working, for instance you've got nurses and occupational therapists working together and they don't have the same pay scale and that's been difficult because the nurses tend to earn more.'*

In a third area, recruitment of NHS staff for physiotherapy has also raised difficult pay-related issues. Following anxieties that recruitment to CMP would divert NHS staff from their existing work, it was decided to deal with this by paying rates for seconded staff to NHS managers at levels which would enable managers to fill posts left vacant with locums. These locums were more expensive than mainstream staff, so there is confidence that NHS managers will have sufficient funds to fill posts left vacant. Initial recruitment was by invitation, with volunteers being sought for secondment to speed up the process of securing staffing for the CMP. With a shift to wider job advertisement taking place at the time of fieldwork, it was felt that specific job descriptions would need to be created. One issue arising here was the need to acknowledge the difference in role, though secondees were operating at their current, substantive, grades. This area was consulting other CMP pilot areas to decide whether to continue with secondments or move to fixed terms of employment. It is anticipated that if they decide to have new fixed-term appointments there will be difficult issues to deal with. These will include an atypical role with a new profile, and how they decide to grade these posts will have an impact for existing seconded assessors. Further staffing issues have been raised by gaps in provision for some customer conditions, a theme to be returned to in the next section.

The CMP programmes have been on a learning curve and are also accommodating uncertain futures. One co-ordinator's vision for CMP was one of practitioners delivering an holistic service. While originally it was not thought that this required any specific professional skills, it soon became apparent that the knowledge and skills of a range of health professionals, in addition to the occupational therapists initially recruited, would be helpful. Evidently acknowledging uncertainties about the future of CMP, another tries to offer staff professional development so that if CMP does fold, they have skills on board to take them into preferred areas.

3.4 The contribution made by clinical expertise

The majority of respondents for the CMP evaluation were from an NHS clinical background. Respondents with a non-clinical background included several CMP co-ordinators, managers and practitioners in the voluntary and private sectors contracted for the delivery of CMP by PCTs and a vocational services manager in the NHS. Respondents with a clinical background tended to feel that delivery of the CMP service by trained clinicians was invaluable. In contrast, respondents with a non-clinical background working in the private and voluntary sectors tended to feel that non-clinicians were making an important contribution to the CMP. This section explores these two contrasting perspectives.

3.4.1 Perspectives of respondents from clinical backgrounds

Practitioners outlined a variety of advantages of a clinical specialist model. The main point in favour of drawing on clinical specialists in CMP provision was the knowledge and experience brought to bear by the specialists. To take an array of examples reflecting this view, a health assessor with a clinical background in mental health emphasised that specialists have a *'huge knowledge base'* and *'a lot of experience'* which gives rise to a *'quality assessment'*. A private sector manager with a background as a cognitive behavioural therapist argued that a clinical specialist model was more efficient as interventions could be focused and relatively short. This respondent noted that therapists write self-help manuals, for example on anxiety and depression and overcoming agoraphobia, by way of reinforcement of his point about the clinical specialist's superior expertise. A psychotherapist stressed how vital the therapeutic relationship was to the success of the group and individual progress through CMP. Prior to CMP, this respondent had tried to run a group using a manual but with leaders who were not trained psychotherapists, but it had not worked well. Clinical specialists referred to *'clinical governance'* giving rise to a service provision being based on the *'best evidence'*. This, it was argued, helped in the identification of when the needs of customers are *'too great'* for the CMP and require further health professional intervention. Proponents of this view indicated how CMP could be *'opening up a can of worms'* if initial interventions were badly made.

Several respondents commented that laypersons would struggle to deliver CMP effectively. One of the area co-ordinators with a clinical background felt that IBPAs would need to have a lot of training to take on a CMP practitioner's role as there is a need to understand stages of health change, and some key health areas such as back pain, anxiety and depression. A practitioner in another area, with a background in occupational therapy, was very concerned that IBPAs would not pick up on subtle information given by a client that would '*scream out*' to a trained occupational therapist. PAs were viewed as likely to find it harder '*to question or challenge or put feelers out about certain aspects of the heath condition*'. A further concern about IBPAs was that laypersons were disadvantaged by a lack of knowledge about how the NHS works. A practitioner who worked as a physiotherapist and also undertook health assessments, felt that clinical expertise was necessary to help people make

sense of their health conditions and what was happening to them. In another area a respondent emphasised the importance of having a specialist health assessor managing pathways into and through the CMP, explaining that if a PA met someone with suicidal tendencies they were likely to panic, where a specialist in mental health would not. Similarly, a practitioner in a different area felt that a layperson might *'panic unnecessarily'* if presented with upsetting symptoms:

> *'I think the crux of it is I wouldn't panic at what's being presented to me, you know. And I'm wondering whether people that don't have those skills do get a bit worried and panicked unnecessarily'*

One or two respondents also emphasised the trust engendered by someone from a clinical health background. A CMP manager described how knowing that they were going to see a health professional gave participants a rapport with the staff member. The ability to empathise with clients was also implied as an advantage of the specialist. A generic practitioner who was a physiotherapist by training felt that clinical expertise allowed not only an understanding of the different presentation of conditions, but provided training in listening to the client in a sensitive and considerate way.

There was some reference to the generic aspects of CMP delivery. One manager from the NHS explained that there are condition-specific and generic aspects of CMP delivery but that most of the CMP practitioners were from specialist backgrounds and brought generic skills to the programme. It should be noted that this manager was not arguing that such programmes should be delivered by clinicians alone. However, a Community Psychiatric Nurse (CPN) in another area felt that detailed clinical knowledge is essential to understand conditions and 'crucial' to delivering CMP effectively, but that this could be done by the private sector as well as the public sector.

Only one of the clinical specialists interviewed in this research felt that it was not necessary to be a trained clinician to add value to CMP. A respondent with a nursing background and a trained occupational psychologist felt that it was important to have *'someone on the social side'* and that a social worker would be a good addition to the team . He added that since joining the CMP, there had been clinical areas that he was not familiar with and the rest of the CMP team had been able to advise him.

Before exploring the views of respondents from non-clinical backgrounds it is interesting to note the comments of a practitioner with a background in physiotherapy working in an area following an in-house NHS model of CMP delivery. This respondent felt that NHS involvement had been crucial to CMP, in health professionals giving far more time to people, as compared to a brief GP consultation. It was explained that this was of fundamental importance because, for *'99 per cent'* of the time, the real reason a person is out of work has nothing at all to do with their health condition, but rather with them not being adequately supported.

3.4.2 Perspectives of respondents from non-clinical backgrounds

As implied above, respondents with non-clinical backgrounds tended to emphasise that there was much merit in contributions being made to CMP delivery by staff with non-clinical training. This view was conveyed by both managers and practitioners. One area co-ordinator providing mostly in-house NHS provision described how her PCTs had wanted NHS practitioners because they felt it would be more likely that they would have 'evidence-based practice' and attached importance to having 'qualified practitioners'. However, this respondent did not feel that it was necessary that all provision be delivered by clinicians, citing work around health promotion as an example. Rather, the skill sets and knowledge bases required in CMP roles would depend on the specifics of the service that needed to be delivered.

Manager and practitioner respondents with non-clinical backgrounds operating in private sector settings were very clear on their added value to CMP. Many of these examples emerged from an area where NHS provision was in the minority as a mixed model of provision was bedding down. In one company, respondents, one of whom had worked for Jobcentre Plus, who were delivering courses on personal development and empowerment felt strongly that soft and practical skills were more important than clinical support. They emphasised that most of their clients did not want clinical support, indicating that there are sufficient clinical skills available beyond CMP that clients can access through their own GP:

> *'I think that people see a doctor and a hospital and medical stuff as apart from work and money and benefit and getting on with life and I think a lot of people don't intermingle the two and I think we fall somewhere between the two camps, don't we?'*

In working with clients it was important for them to be able to listen, to be flexible, not to be judgemental, to be a 'facilitator' rather than a 'tutor' and it was important not to try and tell the clients what to do.

A contract manager in another private company in this area stressed that the organisation's expertise lay in the local labour market and employment, feeling sure that a medical person would be less able to comment on this area with authority. Equally, the respondent would not contemplate providing medical advice and no client had ever asked a medical question in the CMP introductory model it had been running. To take a third example, manager and practitioner respondents from a voluntary sector organisation in mental health emphasised that they were not from medical backgrounds, but were very pleased with the contribution that their organisation was making to CMP. Their delivery of counselling in an informal setting was applauded by a variety of respondents in other organisations. Provision in this organisation included innovations around Indian Head Massage, reflexology and therapeutic massage which was taking provision into waters uncharted by the NHS. Interestingly, a respondent from a health and social care management background working in a management role in the NHS, but in the same area, felt that her CMP provision could not be delivered by a non-clinician, as they were taking a very cognitive approach.

3.5 Gaps in provision and pilot challenges

A learning curve for CMP programmes has been evident in the identification of gaps in provision and pilot responses. Some respondents outlined an operational context in which constructive change was supported as the pilot got underway. Perceiving a gap in provision for those customers who want to get fit and healthy, one area had piloted a lifestyles programme to address this, which was *'hugely popular'*. The biggest challenge was seen as how to make it county-wide. One respondent, a health assessor, was particularly impressed by the relative freedom to make changes:

> *'…that's another thing that I like about it, that something's not working so we can change it. You know you're not bound by huge pillars of this, you know, departmental pillars. You know to make small changes in the NHS is not easy. Within Jobcentre Plus I've found out with working with colleagues that you know, making huge changes isn't that either, but with the pilot we've been allowed to make those changes and allowed to develop things so if something doesn't work, "ok well we'll change it". Not just change for change's sake, but....if we've seen either gaps in the markets and there are things that customers need – it's kind of being able to go and look for that.'*

Over time, pilot areas have made revisions to programme structure. In one area, fewer providers are being drawn on for the introductory course so that there is more consistency of delivery across the area as a whole. While participation in CMP gives customers the opportunity to think about their condition and the practical requirements of getting back to work, some providers have found that having this discourse with customers at the end of CMP participation works much better than having it at the beginning. Issues around introducing the work focus for customers are explored in greater depth in Chapter 4.

Customers for whom there seemed to be a provision gap included substance abusers, customers with ME and diabetes and neurological conditions. One area has been trying to fill gaps in provision as they go along and reporting a growing expertise in working with ME customers. Another area, originally committed to an approach targeted at people with specific conditions, has become more aware of the disadvantages of a specific service model. The CMP team always knew that some conditions would fall between the identified categories, for example, chronic fatigue syndrome and fibromyalgia in a customer combine both mental and physical conditions. They expected these, and were prepared to have to deal with them. However, as time passed, people with other conditions not originally envisaged on the programme, such as diabetes and neurological conditions, have increasingly been referred. They originally expected to discourage referral of such people, but are trying to adapt to a reported change in the national policy perspective towards making some provision for all potential customers who could benefit from increased knowledge and confidence to manage their condition. The original service model did not contain the skill mix and profile to deal with this, but they are trying to adapt this. What tends to happen is that people with conditions which do not fit neatly into one stream of CMP see a physiotherapist first, who acts as a general case manager.

In one area, CMP was reported as having created tensions locally between some services for two main reasons: Firstly, the self-management approach was seen as having had low priority within the NHS and Department of Health and secondly because the CMP is perceived to be receiving money that other services have been denied for years. As one senior manager explained:

> *The biopsychosocial model is still of tertiary importance in the NHS. Not primary, not secondary, it's way down there. So this idea of secondary prevention, self management, is only just bubbling up now through the DH* [Department of Health] *agenda, really over the last year. So there was a lot of bad feeling when that started.*

There was some concern that that there might be a danger of duplication of NHS and voluntary sector services. However, it was felt that the approach adopted in CMP is the most evidence-based in terms of clinical effectiveness and most closely aligned to a forthcoming National Service Framework for musculo-skeletal conditions. As noted earlier, another area has been working to avoid the duplication of health services, undertaking a preliminary *'mapping of local services'* to ensure the CMP did not *'create any conflict with any services'* or replicate existing services.

In addition to the staffing capacity issues raised earlier, there has been an issue around availability of local venues for delivery. Some pilot areas have had to be creative in finding locations for provision. For example, one pilot area reported how it has been challenging to find accommodation in the community to deliver services, and providers have made use of church halls and leisure centres. Some PCTs with contracted out provision raised this as a concern, since they were not very happy with the standard of premises being used by providers.

The broader environment in which CMP is operating was also acknowledged to be important. One manager respondent was particularly anxious about what would happen if the labour market were to change, with fewer jobs available. He explained that at the time of the pilot programme there are jobs, and it is realistic for the service to help people acknowledge that they have a worthwhile role, with some rights, and help them to assert themselves, and pursue labour market entry, despite health conditions. If the economic context was different, this would be much harder to justify and deliver.

3.6 Provider quality management in contracted out provision

All areas with contracted out provision reported quality management issues that needed to be addressed and had made varying degrees of progress towards doing so. In one area, although the mental health component of CMP had been contracted out, there were no formal quality standards at the time of fieldwork. The co-ordinator respondent for this area identified this as a difficult issue. The area's main standard is effectiveness in getting people back into work, and customer satisfaction, but there is no structure for measuring this. An additional management

post was planned for the near future and part of the appointee's remit will be to do random checks, and ensure consistency in process and interviewing. Thus far, feedback from a range of stakeholders, including IBPAs and customers has been largely positive, if not systematically gathered. Generic interventions are seen as more patchy in their quality. For example one provider picked up the idea more quickly than the other two and rather shaped it according to their perceptions which were slightly different from what CMP originally envisaged. In another area, case managers were having to invest a considerable proportion of their own working time in ensuring that contracted out provision was running as advertised.

Managers using contracted out providers were also concerned about the ease of tracking customers. In one area it was felt that unless contracted out provision was brought clearly within a CMP team there was a danger of a lack of monitoring and support through *'peer review'*. These fears were addressed in the case of one provider because they already provided primary care services and had a service level agreement. Extensive discussions were held with this provider about clinical expectations and service level agreements were based on the provider's own standards, the professional standards for each practitioner group, and Trust standards.

In another area, quality standards are largely built into area service level agreements. These agreements stipulate the quality of staff required, for example, counsellors have to meet strict criteria around qualifications and registration and contractors must take responsibility for clinical supervision and performance. For most providers quality management issues have largely not arisen. However, the introduction of a mixed model of provision was accompanied by mixed provider understandings of what the lead PCT wanted, and the co-ordinator has had some work to do to ensure consistency across providers. Due to a high volume of customers, it was known from the outset that moving people through the programmes was going to be *'extremely important'* . However, a couple of providers, though supplied with standard administrative forms, had not initially complied with administrative procedures. For example, providers were supposed to tick programme attendees off on a register but were failing to provide basic registration details or supply quarterly figures. To tackle these issues the co-ordinator met a group of providers.

Working with varied providers in largely untrodden territory has called for a commitment to following up customer feedback. Two areas had set up a reference group of customers who have graduated from CMP, and because of their participant experience are in a position to feed back in terms of peer review. In one area, this was at an early stage, while in the other, these customers are feeding back half-yearly on activity and progress. Furthermore, there is a customer liaison manager whose remit includes addressing the quality and the effectiveness of the programme as the individual goes through it. As the co-ordinator explained:

> *Some people they get so far and then they don't attend or they cancel, and what we want to do, is strengthen that follow-up, so we do have a system whereby we ring people, we say "Just a reminder, you've got your course tomorrow. How are things? Are you still feeling well?" , so we're building that in and strengthening that, because it is that personal contact which seems to make all the difference.*

In another area, administrative changes, including database improvements, have given CMP administrators more time to do some of this customer liaison work. Administrators talk to providers on a daily basis. The co-ordinator and her two project managers also have a monitoring system involving frequent visits to providers, sometimes unplanned, quarterly returns on activity; validating those returns against the CMP team's finances. While working with block contracts, the central team is 'very keen' to develop contracts that monitor value for money for programme participants. Several other factors facilitate this area's provider quality management, including facilitating customer feedback and involvement, daily communications and formal monitoring. Each customer has a contact number in the event that they need to talk about programme quality.

4 Working with customers – Condition Management Programme practitioners' and managers' perspectives

4.1 Introduction

This chapter explores Condition Management Programme (CMP) practitioners' experiences of working with Incapacity Benefit (IB) customers. It begins by considering the types of customers being seen, and the extent to which this is consistent with the customer profile they had anticipated. It goes on to discuss customers' initial expectations of, and responses to, CMP. Ways of working with customers, and the nature of progress observed as a result, are then discussed.

4.2 Customer profiles and take-up of the Condition Management Programme

Mental health problems were cited as widespread across all districts, and were more common than some people had anticipated, often having developed as a secondary condition. While some practitioners described their caseload as containing a good mixture of mental and physical conditions, others commented that as many as 80 per cent of the customers they saw had mental health problems, and this group was generally viewed as harder to help. Younger people, perhaps counter-intuitively, were regarded by some practitioners as a difficult group to work with, because they were not always good at attending regularly, and because younger men in particular sometimes found it hard to talk about their problems. CMP was, however, felt to be reaching these groups, which do not always take up NHS services. Take-up among ethnic minority customers, especially women, was reported to be low, and one area was doing research to explore whether there were unmet needs among this group.

There had been a fairly widespread mismatch between the type of customers CMP services had anticipated and those practitioners were actually seeing on a day-to-day basis. Some felt that the customers seen were not in the 'mild to moderate' category they had expected but had more severe and enduring problems. For example, one manager expected that people would have worked in the recent past, and would have short-term health conditions, but had found that this was rarely the case in his area. A practitioner with a mental health background commented that he was dealing with several cases of severe depression, mostly involving long-term use of medication, and that some were receiving community mental health services. A number of practitioners commented on the complexity and difficult circumstances of customers' lives, which had sometimes been a surprise to them. There were widespread instances of customers disclosing information, for instance on past sexual abuse, that they had never felt able to tell anyone before.

One issue for practitioners working in generic roles was a lack of experience in some of the conditions they were faced with, and a concern that they might miss something of importance or exacerbate a condition. So for instance, those with physical specialisms sometimes felt ill-equipped to deal with mental health problems, and those with mental health expertise worried that they might be encouraging people to take on tasks which were too physically demanding for their condition. This was also seen to affect patterns of referral. A case manager noted that she had few referrals for physical exercise programmes from her mental health colleagues, as they were less attuned to the benefits of such provision.

As with Incapacity Benefit Personal Advisers (IBPAs) (Barnes and Hudson, 2006) some CMP practitioners felt that existing customers were harder to work with as a group, both because of the length of time since they had worked and their health conditions, while others saw this as something they could only make judgements about on an individual basis.

4.3 Customers' initial expectations of and response to the Condition Management Programme

CMP practitioners felt that many of the customers referred to them came along with no clear ideas about the service they were being offered, and some practitioners were concerned that IBPAs might have *'targets'* for CMP referrals which influenced their practices:

> *'I think they've got targets… They're very much sell, sell, sell with clients and clients come to us and say, "I just feel I've been pushed into this". Whereas with us we explain it's voluntary to them and we've not got an agenda... we're just trying to empower them.'*

Practitioners commented that many customers did not really understand why they had been sent for assessment. There was also a widespread view that not all customers were aware that participation was voluntary *('you can't take it as read that they do'*), and that some had initially attended because they feared an adverse impact on their benefit income:

> *'Even though the IBPA hasn't said "You have to go", the customer still feels somewhere along the line they are going to lose their benefits if they didn't come.'*

This is supported by customers' own reports; while understanding that participation was formally voluntary, some reported feeling under pressure to take up suggestions made by their IBPA (Corden *et al.*, 2006). This was something which was seen to have been more prevalent in the early days of implementation but was still a live issue in some areas.

CMP staff felt that customers sometimes came to their first appointment expecting treatment (e.g. physiotherapy) and were disappointed when this proved not to be the case. Again, this was an issue which was seen to have declined in importance over time, as IBPAs had become clearer about the role of CMP and communicated this confidently to customers.

Some practitioners, using the medical term *'triage'* as an analogy, argued the case for an initial telephone conversation with customers, prior to their first appointment, to ensure that the referral was appropriate, avoid a mismatch with customer expectations, and prevent high rates of people failing to attend. In other areas, this was already happening, and was perceived as helpful. The first appointment was generally used as an opportunity to develop an in-depth understanding of customer needs and priorities, and where the case manager approach had been adopted, to assess which services might be most appropriate:

> *'You're searching for what they enjoy, what their lifestyles are now, how accessible places are, how convenient. You know, you've sometimes young mothers who've to pick up children, so it's no use suggesting a three o'clock class.'*

Practitioners had generally been pleasantly surprised at customers' responses to provision, finding the majority of people they saw highly motivated, despite often severe health problems and complex issues, such as housing problems and debt, to deal with. Few reported customer resistance to what was being offered, but practitioners in some areas commented that this was widespread. One commented that he had initially been *'naïve'* and now felt that many people were not motivated to return to work, saying that he had started out:

> *'...thinking that everybody out there that wasn't working would like to work, and if their health condition was proving a barrier, they would like to try and overcome it. PC or not, I'm sorry, but that has not been my impression.'*

Another reflected that the apparent lack of interest shown by some groups was the result of having been overlooked by the system for so long that they have become discouraged.

Practitioners were keen to ensure that those they worked with really wanted to take part, as there was otherwise seen to be little benefit in participating. They spoke of this in terms of *'looking for a commitment'*, making sure that people were *'on*

board' and that they were actively engaged, rather than passive. One practitioner had sought to ensure this by asking people to phone her after the first appointment and confirm their wish to take part:

> *'If they don't phone me back they're discharged. They've actually got to want to do it. If they don't want to do it they're not actually going to benefit from it anyway. Because there's no point just turning up and being passive. It's quite active.'*

Because of this, those who decided not to take part after an initial appointment were not generally regarded as having 'dropped out' but simply as haven chosen not to take part. Similarly, CMP staff also 'counselled out' a proportion of those referred to them. This tended to be in cases where they believed that work would be detrimental to a customer's health condition, where the customer had too many unresolved issues (e.g. drug and alcohol abuse) to benefit from the programme, those awaiting treatment on the NHS which would have a material effect on their condition (e.g. surgery or counselling for long-term issues) and those actively undergoing NHS treatment, where CMP involvement was seen to have a potential for *'muddying the waters'* by sending out conflicting messages. Some practitioners had revised their position on these issues over time. One CBT course which had at first explicitly excluded those misusing drugs and alcohol had successfully worked with customers in these groups, once the leaders became *'less scared'* and felt able to take the risk. Practitioners did not view CMP as unsuitable simply because of a particular condition, or because the customer was a long way from work; it was more an issue of knowing that the person would derive some benefit from taking part, and thus an individual decision.

4.4 Ways of working with customers

4.4.1 One-to-one work

Customers were being seen in a variety of settings, reflecting both their own expressed wishes and the therapeutic aims of practitioners. Many meetings were held in Jobcentre Plus offices, and for some customers this was seen as helpful in reducing the emphasis on medical issues. A practitioner working with mostly young people noted that many were reluctant to go into the jobcentre and was happy to meet them in a local pub. Many CMP practitioners also offered home visits where needed, although this was time-consuming and not generally a strategy of first resort. In some cases, meetings were held in social spaces such as cafes, sometimes specifically in order to tackle issues such as phobias or rusty social skills. For other practitioners, the fact that a customer was prepared to make the effort to attend an appointment in a jobcentre was seen as a useful proxy for their closeness to work:

> *'Well for me it really looks at their motivation. Because if they come to you at the Jobcentre they're showing willingness to join the programme…if people wanted help, if they came to you,…if they regularly turned up for an appointment, you knew that they were motivated to make a difference.'*

One-to-one work frequently involved the use of action plans and goal-setting. The latter could be as simple as getting a customer to commit to getting out of the house and taking a walk three days a week. Other tools used included an activity diary which is used to record activity and link this to pain reports, so that an individual can obtain a better sense of what triggers pain, and learn to manage their own condition more effectively. Motivational interviewing was also noted as an effective tool in working with customers.

4.4.2 Group work

Group work modules were being offered in all districts. These included both generic provision, such as exercise on prescription, cognitive behavioural therapy (CBT) and introductory CMP modules and condition-specific modules, for instance on pain management, depression, anxiety and sleep problems. The former were seen as useful in providing customers with a sense of how they could benefit, increasing their activity levels, and providing a routine and structure. They also covered a range of issues related to health and employment, such as goal setting, communication, stress management and healthy lifestyles. The latter were seen as particularly helpful in offering targeted help, overcoming resistance to participation and in offering customers peer support. The sense of safety offered by the group was seen to be important, as customers are encouraged to be comfortable and open with each other and become more self-aware over time, resulting in them *'not being alone,* [knowing] *there are people in the same boat'.* Another typical comment was:

> *'...because it's a depression module you can coax them into that group much more easily because they know that everybody else in the group's going to be the same.'*

CMP practitioners felt that group modules were of particular value in tackling certain kinds of issues, for instance improving social skills and self-confidence where people have become isolated, but acknowledged that some customers could find it difficult to engage with such provision. Existing customers, who had not worked for a number of years, were noted as being particularly reluctant to attend groups, an issue which was also evident in the early implementation work with existing customers (Barnes and Hudson, 2006). Some IBPAs found that customers became more willing to join a group after a period of one-to-one work, and some made a point of phoning for a chat with customers the day before a group course began, to remind them, and to allay any concerns they might have. In another area, a generic CBT course was preceded by a 'meet and greet session' to which customers were accompanied by a CMP case manager, and where they were allocated a ten-minute individual session with the therapist to discuss any concerns or anxieties which they might have. This was noted as having improved initial attendance and retention rates.

In rural areas, customers were reported as sometimes being reluctant to attend group sessions, because of confidentiality; the continuing stigma attached to mental health problems was a particular issue in this respect. In one area, customers

who were really reluctant to talk about their problems in a group setting had the option of a computer-based CBT programme, and this was viewed as having had positive results. However, customers were required to attend a local centre to use the programme, providing some structure and a degree of social interaction.

Groups were seen to benefit almost everyone who did attend them, and CMP staff commented that most people did attend on a regular basis once they had made the initial commitment.

4.4.3 Introducing and maintaining a work focus

There was wide variation in how and when CMP practitioners introduced a work focus. Some saw this as central to their work with customers and were keen to introduce it from the outset, although they were careful about how they did so. Work was seen as a *'sensitive'* issue which had to be introduced *'gently'*. Some practitioners did this by talking about a previous job, and exploring whether that type of work would still be suitable, while others approached the issue in a more gradual and roundabout way. A typical comment was:

> *'I don't focus right in on that straightaway. I think you can lose people that way.'*

Nonetheless, practitioners in this group were strongly supportive of the work focus in the pilot, and felt that it was a primary objective of their work with customers. One, who noted wryly that many customers *'hated'* discussing employment, said *'that's unfortunate, but that's why we are here really'*.

Not all practitioners felt that talking about work was problematic. Some felt that most of those engaged in CMP were already motivated and focused on the issue of returning to the labour market. Others saw the issue of employment as something to be tackled once other barriers have been reduced or removed, and acknowledged that many people had simply become overwhelmed by their problems and lost confidence in their ability to get back to work:

> *'I mean they're wanting to go back to work, they want to become a useful member of society again, because they've no confidence, their self-esteem's gone, they feel inadequate, they feel they're not supporting their families and, yeah, they want to do something useful.'*

Many practitioners argued that there was a natural progression to thinking about work once health barriers had been dealt with, seeing this as part of the recovery process. One, who said that she *'never'* began her work with a customer by talking about employment, commented that:

> *'We're here firstly, as far as I'm concerned to improve the quality of life and improve management skills. And then for 99.9% of our customers that leads to them wanting to return to work.'*

In one pilot area, a group module had initially focused on employment issues at the start of the course, but providers had found that this did not work well, and that

customers had responded much more positively when work was introduced as an element in a 'graduation' stage.

4.4.4 Managing the end of the CMP process

Practitioners were keen to stress that CMP is intended as *'a brief intervention'* and there is a need to avoid *'creating dependency'*, which can arise when services are *'needs led'*, tailored to an individual and involve large amounts of contact. One practitioner spoke of the importance of maintaining *'good case hygiene'* by finishing work with someone once they have made a reasonable degree of progress, rather than becoming over-involved. As well as 'graduation' days, there were also meetings with IBPAs in some areas. These formally marked the end of CMP involvement and the transfer of responsibility back to the IBPA, and as noted above, often involved a renewed focus on employment.

4.4.5 Customer outreach and publicity

Across all areas, customers were reported as mainly hearing about CMP via their IBPA.

Some practitioners were keen for GPs to be more actively involved in making patients aware of CMP, and in some areas there were outreach sessions being held in surgeries and health centres. However, it was still necessary for people to be referred formally to CMP by an IBPA, and to be in receipt of a qualifying benefit, so there is a potential for raising expectations among those not eligible to participate.

Some CMP practitioners were keen to publicise their services in community-based venues, as they felt that it would be easier to get their message across in a setting where people felt relaxed and comfortable, but this did not appear to be happening on a large-scale basis.

Leaflets and other written materials were available in some areas, but not everyone was happy about the style and content of these publicity materials, which were often simply photocopied sheets in black and white. There was also a desire to create additional information resources for customers, for instance by collecting leaflets and handouts on particular conditions, but time for such activities was felt to be limited.

4.5 Customer progress and outcomes

Practitioners reported a full spectrum of progress among customers, from those who made rapid and extensive progress, to those were *'not engaging'*, had moved only a small distance, or who had become 'stuck' at a certain stage, for instance becoming despondent after failing to get jobs. Those failing to progress were noted as having more complex personal problems, which required specialist help, and practitioners felt that some customers would need more extensive assistance to overcome self-limiting beliefs and attitudes. This was clearly identified as an issue of

motivation rather than being related to the severity of the health condition. One practitioner expressed his frustration at people who seemed *'resistant to anything that might be of use to them'*.

There were many examples of success stories: One practitioner described someone who had initially been unable to face going into a supermarket, as having felt ready to return to paid work after their three-month involvement with the programme. Examples were also given of people who had been suicidal or self-harming at the start of the programme, but who had not only managed to tackle this issue, but had successfully returned to employment. People with severe mobility problems and pain had also returned to work, in some cases to the considerable surprise of CMP staff. Practitioners commented that they found it quite hard to tell at the outset which people would make rapid progress, and also noted that successful outcomes were a result of both CMP and Jobcentre Plus interventions.

Observing customer progress was a key source of job satisfaction for practitioners– improved confidence, self-esteem, physical appearance and stamina were all noted as immediately observable effects of participation in CMP. While acknowledging that a return to paid work of over 16 hours was *'the gold standard'* from the point of view of Jobcentre Plus and *'an absolute aim'* of their work, CMP practitioners also had additional outcome measures (some of which they characterised as intermediate stages or *'interim outcomes'*) in mind when working with customers. These included reduced need for medication (e.g. lower doses of painkillers or anti-depressants), more effective use of medication to control the condition (which might mean using more pain relief, for instance), increased functioning (e.g. being able to leave the house, use public transport or visit the dentist after tackling a phobia) and improved quality of life (e.g. joining a walking group or gym). In some cases, single or multiple standardised outcome measures, such as an inventory of coping skills, were used at the start and end of the programme to measure distance travelled. Practitioners emphasised that progress needed to be considered relative to the individual's own particular circumstances. One gave the example of a customer with bipolar disorder who remained at some distance from the labour market, but had embarked on an educational course, saying:

> *'What's a big step for him as an individual might be a tiny eenie weenie baby step for someone else.'*

Practitioners felt that these types of outcomes represented positive stages in recovery which could well translate into an eventual job outcome, but possibly not for several years. Examples were given of people, such as those who had left work because of stress-induced mental health problems, who needed to make a very gradual return to work if it was to be sustainable over the longer term. One practitioner noted that it was common for customers to move on to Permitted Work or to begin with a very low number of hours, but commented that this did not necessarily show up as an employment outcome.

On the other hand, several managers and practitioners noted that they had been surprised at how many people have in fact returned to full-time paid employment. One felt that some of the outcomes she had witnessed were *'an absolute miracle'* while another spoke of:

> *'...people who from a literature and an evidence point of view, maybe before would have been written off as not having any possibility of returning to work, and I think that's what's really surprised me, how with the right support, some people have so much to offer that they didn't know they had.'*

A point that was made by many practitioners was that many people require a period of support when they first return to work, if they are to make a success of it. This comment was typical:

> *'I think you've got to, I think you should offer some kind of support once they go back to work... it's no good if these people go back to work and then they go straight back on the sick and then they're back on our books again, if you just give people a little bit of support maybe they'll stay in their job.'*

Some practitioners referred to using the designated in-work support provider for their area, and examples were given of customers who had benefited from this.

CMP practitioners also felt that CMP had the potential to play a valuable role in job retention more generally, and some felt strongly that this was an area that should be developed in future, to prevent people's problems becoming entrenched over a period of years. However, some doubted whether people still in employment would be sufficiently alert to the value of such a service to make good use of it.

The types of progress which CMP practitioners observed and considered important were felt not always to be well represented by the standard outcome form returned to Jobcentre Plus. One, who described the forms as *'quite restrictive'* said that *'people don't necessarily fit into the forms as they exist'*, while others noted that they always entered information that they considered important in the free text area of the form. In some areas, CMP had their own outcome forms (and in some cases used questionnaires or telephone follow-ups to track outcomes and obtain user views of the services provided) while in others, tracking measures and ways of measuring distance travelled were evidently at a very early stage of development.

5 Working with other agencies – Condition Management Programme practitioners' and managers' perspectives

5.1 Introduction

This chapter explores the extent and nature of CMP practitioners' and managers' involvement with other agencies. The relationship with Jobcentre Plus is obviously central to this discussion, but the successful operation of CMP also involves liaison with a range of other agencies, which may include GPs and other health professionals, job brokers, employers and local voluntary sector agencies.

5.2 Working with Jobcentre Plus

Those interviewed had not generally had previous experience of working with Jobcentre Plus, and most CMP practitioners knew little, if anything about the Pathways to Work pilots before applying for employment, so that they did not necessarily begin with a very definite idea of their role within the pilots, or of the inter-agency work that would be involved. They also did not necessarily have a clear sense of how CMP contributed to the overall aims of the pilot; this had tended to develop over time.

A number of CMP practitioners were based within Jobcentre Plus offices. This was seen to have advantages in facilitating informal feedback and contact, and referral levels were noted as having increased where CMP practitioners were located in the same building. However, the practicalities did not always work so well. In one area,

it had taken months before CMP staff located in Jobcentre Plus offices had access to email. It was also reported in some areas that Jobcentre Plus staff had priority for room bookings and it was not always easy for CMP practitioners to access suitable premises for consultations.

Many CMP managers and practitioners referred to *'cultural differences'* between themselves and Jobcentre Plus. This was partly an issue about how staff relate to customers – some health practitioners tended to feel that they were more empowering and enabling in their practice, and that Incapacity Benefit Personal Advisers (IBPAs) had a more directive approach. However, one practitioner commented that she had been particularly impressed by the *'compassion'* shown towards customers by IBPAs, and felt that they were genuinely concerned with people's best interests, saying *'they weren't there just to get them back to work, they really did seem to want to help them'.*

CMP practitioners had different experiences of working with IBPAs. Some described close and mutually supportive working relationships, while others rarely saw the PAs who made referrals to them, and felt that PAs had a limited understanding of the purpose and role of CMP. This may also have reflected differences in the stage that working practices had reached at the time of the fieldwork. Practices which were noted as helpful in improving communication included regular joint IBPA/CMP meetings and seminars, CMP practitioner attendance at Work Focused Interviews (WFIs), providing informal feedback on customer progress, and in some cases a formal handover (which took the form of a three-way meeting between the IBPA, CMP case manager and customer in one area) at the end of the programme.

One CMP co-ordinator commented that, at a strategic level, there could be a limited understanding by Jobcentre Plus of the overall priorities and agendas which shaped the work of the Primary Care Trust (PCT), and that this could lead to some tensions, especially if the PCT felt that it was being treated *'as a provider, not as a partner'* . The importance of a good working relationship with the District Implementation Manager was emphasised by several co-ordinators.

5.2.1 Referrals from IBPAs

Most practitioners reported that the referrals they are receiving are broadly appropriate and in line with the numbers initially expected. This was also an area which had improved over time, as CMP practitioners clarified their target group and communicated this to Jobcentre Plus. Some areas have developed formal referral criteria, and one had written a 'FAQ' (frequently asked questions) leaflet for IBPAS, but some practitioners argued that they would far rather err on the side of being 'inclusive' even if this meant a proportion of unsuitable referrals. In some districts, CMP practitioners were attending a jobcentre one day a week to provide information to IBPAs and customers, and in others, they were attending the second WFI, either routinely or on request, but not all CMP services felt that this level of involvement in referrals would be appropriate or helpful for them.

Although not widespread, there was some evidence that IBPAs were referring to CMP in cases where they were unsure what to do with customers. A practitioner in one area noted that she had been asked to see a woman who had never worked and did not speak English, whom she had felt unable to assist, while a practitioner in another area commented that referrals for the group provision they were running were not always appropriate:

> *'...we've had quite a high number of very seriously mentally ill individuals. Now sometimes it's because they're volunteers and fine, we will work with them, but I think that IBPAs need quite a lot of support in ensuring we get the right customers into this course, because there's very little point in taking people simply because the IBPA doesn't know what else to do with them.'*

In some districts, particular Jobcentre Plus offices were noted as having very low referral rates, despite many attempts to stimulate these, and this was a cause for concern among CMP managers. Increased outreach, with the aim of increasing demand from customers themselves, was one response to this issue. However, CMP practitioners in other areas commented that they saw the IBPA's role as crucial to managing both the number and the suitability of referrals. The second report on the longitudinal customer panel (Corden *et al.*, 2006) has noted the importance of the IBPA as a gatekeeper to other pilot services, and shown that customers are sometimes deflected from their desire to take up a particular service.

A related point is that both the number and type of referral was also noted as varying from one IBPA to another. Some practitioners felt that the main reason for unsuitable referrals was IBPAs' lack of familiarity with CMP, and that this could be tackled by improving communication, others drew a distinction between what they saw as *'responsible'* IBPAs and those whose keenness to achieve job targets was thought not to operate in the best interests of all customers.

5.2.2 Contact with IBPAs during CMP and at completion

The degree of contact CMP practitioners had with IBPAs while working with customers varied considerably. In some cases, and particularly where the practitioner and IBPA were based in the same office, this was frequent and informal. An example given was of checking whether a customer was also failing to attend WFIs, where they had not turned up for a CMP appointment. Telephone contact was also common. In other areas, there was less ongoing contact, outside the formal referral at the outset and the completion of outcome reports or a 'handover' meeting at the end of a customer's involvement with CMP. Some practitioners commented that they would have liked further feedback about customer progress once they had formally handed the case back to Jobcentre Plus.

5.3 Working with other agencies

5.3.1 Job brokers

Job brokers were reported as being fairly widely used, mainly for referrals following the completion of CMP. In some districts, CMP practitioners had day-to-day contact with job brokers, while in others this was an area that fell to IBPAs to deal with. Some CMP practitioners were obliged to pass customers back to the IBPA for a job broker referral, but would have preferred being able to make the referral themselves, as they felt some job brokers were markedly better than others.

While some practitioners had made extensive use of job broker services, and were *'very pleased'* with them, for others there was a lack of familiarity with job brokers, concerns about *'rivalry'* between competing providers, and some instances of negative feedback from customers. Some CMP practitioners felt that the funding base for job brokers meant that they were a little too keen to encourage customers back into work, regardless of whether this was appropriate for them, and were inclined to be wary of them for this reason.

> *'They always seem to be touting for trade and they're always… like, looking almost to get customers. And I don't really like that attitude.'*

5.3.2 General practitioners

Contact between GPs and CMP was widespread across all pilot areas, but it took different forms: In some areas, there was a formal protocol, with a letter being sent to the GP, with the customer's consent, at the start of the process, while in others this was not a feature. There were reports of CMP making contact with GPs in relation to specific concerns about customers, for instance in cases of suicidal ideation and psychosis, and where reported symptoms suggested a need to exclude cancer as a possible cause. In some districts, the main form of contact with GPs was in the form of outreach sessions held at surgeries. This could, however, create *'mixed messages'* about the target group for the pilot (see section 4.4.4, above) and create demand among those not eligible. Some practitioners made a point of maintaining contact with local practice nurses, who were felt to be in touch with customer needs.

There had been minor issues with GPs in some areas, for instance, attempts to charge Incapacity Benefit (IB) customers for permission slips needed in order to take part in exercise programmes, but these had been resolved without undue difficulty.

A more substantive point raised by CMP staff in some areas was the importance of GPs being 'on board' with the philosophy of CMP, i.e. encouraging and empowering people to self-manage their condition, rather than defining health conditions as problems which can only be dealt with by medical experts. Where GPs took the latter view, they could act as a barrier to a customer returning to work.

5.3.3 Other health professionals

As with GPs, contact with other health professionals was a feature of CMP practitioners' work across all pilot areas but was generally more limited in scope. In some districts, CMP practitioners had been involved in giving presentations about their work. Most commonly, however, practitioners were involved in liaising with other professionals in relation to an individual customer, or in making cross-referrals, for instance to physiotherapists or community psychiatric nurses. In some areas, health professionals were able to make direct referrals onto CMP modules; and some managers found it beneficial to create modules which were not wholly for CMP customers, feeling that the mixed funding base created more financial stability.

5.3.4 Voluntary sector agencies

In addition to contracted-out provision delivered as part of CMP, contact with voluntary sector agencies was occurring both in relation to customer referrals, often for specific issues (such as drug and alcohol misuse, mental health problems, domestic violence and debt counselling), and as a source of voluntary work experience. In some areas, CMP practitioners attended local voluntary sector network meetings, while in others, customers were provided with an information pack on local agencies. Several practitioners mentioned one or two key organisations to which they had made a number of successful referrals.

In some areas, voluntary work was felt to have been of great value in providing customers with an opportunity to try out a return to work with minimum risk, and referrals to the volunteer bureau featured regularly in CMP practitioners' work.

5.3.5 Employers

Contact with employers was reported as being very limited and only a handful of the CMP practitioners interviewed was involved in providing in-work support. Some practitioners felt that there might be potential benefits in liaising with employers in the future, particularly in relation to job retention issues, and in terms of a more broadly educational role (e.g. providing them with information on specific conditions, or about the range of adjustments which could benefit someone with a health condition), but had so far had few opportunities to do so, while others felt strongly that this should not be part of their role:

> *'I've never spoken with an employer. I don't really feel that's my job to do that. That's when the in-work support and people like that get involved.'*

In some cases, this reluctance to work with employers was motivated by issues about client confidentiality, while in others there was a concern to maintain defined professional boundaries between health workers and other people involved in pilot provision, such as job brokers and Jobcentre Plus staff:

'I think we'd have to be very careful that we're not taking over from the jobcentre. I think that there's a bit of an instinct in wanting to take on bits that they maybe haven't got the time to do or potentially we could do better because it's a slightly different approach. So I think we need to be careful that we look at where our role stops and theirs begins...'

Some CMP managers envisaged doing more work with employers, particularly large local employers such as local authorities, in the future, but felt that they had lacked the capacity to engage in such strategic initiatives during the first year or so of implementation, when they were still getting to grips with their own service design and delivery. Others were very clear in their view that this was outside the CMP remit.

5.4 The importance of inter-agency working relationships

Many of the CMP practitioners interviewed commented that networking with other agencies was a key element of their role, both to access complementary provision and avoid duplication of services, and to market CMP, and said that this was something they would seek to emphasise to those developing CMP services in new pilot areas. This was often something which had not been a major part of their previous professional experiences, and some had found it uphill work at the beginning. Some areas had also found that they needed to scale back their involvement in networking activities once CMP became established, as they are quite time-consuming.

6 Overall views of the Condition Management Programme, emerging conclusions and implications

6.1 Introduction

This final chapter draws together some overall views of the Condition Management Programme (CMP) from previous chapters, and identifies some emerging conclusions. It considers the implications for future development of CMP, and provides some advice for services being developed in new areas.

6.2 Job satisfaction among Condition Management Programme staff

Both CMP managers and practitioners reported very high levels of job satisfaction and transmitted a real sense of enthusiasm and commitment to the service. Working for CMP was described as *'really rewarding'*, *'an absolute plum job'*, *'a bit of a dream come true really'* as well as offering *'a steep learning curve'* and being *'daunting'* and *'challenging'*. Some people particularly enjoyed the scope for creativity which they felt was offered by being involved in pilot provision. The variety offered by the work was highly valued, as was the degree of customer contact involved. Many providers saw the opportunity of *'making a real difference'* in customers' lives as key to their own job satisfaction, and described this as something which gave them *'a real buzz'*.

Those who had previously been working in NHS settings commented on the increased satisfaction offered by being able to offer preventative health care, allow longer appointment times, and provide continuity of care. These were factors which they felt enabled them to address deep-seated issues and problems, rather than simply treating the presenting condition. The ways in which provision had been set up were also felt to offer flexibility to respond to issues as they arose, in contrast to the inflexibility of NHS bureaucracy, where there was a perception that change could take years.

Some CMP practitioners, who had been attracted to the initiative precisely because it represented a development challenge, were *'used to hitting the ground running'* and had not found this daunting. Others had experienced this aspect of running a completely new service more negatively, finding the lack of a clear sense of what CMP was intended to deliver, and in some cases poor infrastructure in the early months of operation *'stressful'* or *'scary'* and feeling *'unprepared'* for the *'massive'* task they had taken on.

Travel time was an issue for practitioners in some rural areas, where home visits to customers could involve a lengthy journey. In one area, lack of compatibility between Jobcentre Plus and NHS IT systems had meant CMP staff driving long distances to pick up emails during the early stages of implementation. Some practitioners also mentioned that they could easily feel *'out of the loop'* when working away from their own office setting, whether in a jobcentre or doing home visits, for extended periods.

As discussed above, it could be demoralising for practitioners when large numbers of customers who seemed at a considerable distance from employment were referred to them, and this was something which had needed to be negotiated in defining referral criteria. Several practitioners described having people fail to attend as one of the worst aspects of the job, since lengthy appointments were allocated and it was hard to make best use of this time when people did not cancel in advance. This was seen as inevitable on first appointments unless customers came along with a clearer idea of what they were being offered, for instance, via outreach sessions, and there was an explicit aim of introducing such sessions in some areas. A slightly different issue was that of customers failing to attend once they had made progress, rather than formally ending their involvement. This could give rise to a certain amount of soul-searching among committed practitioners, who would have preferred to reach some kind of closure.

An issue which was of particular concern, especially to managers, was the rapid shifts in policy, particularly the decision to roll out Pathways to Work (including CMP) to the next 14 areas, which was seen as placing a potentially damaging strain on NHS resources, and raised issues about capacity.

6.3 What is working well?

The voluntary nature of CMP was identified as important by many of those interviewed. Practitioners emphasised this when they met customers, to reassure them about the lack of compulsion to take part, and felt that the customer's decision to engage was an essential part of the process of their empowerment, and taking active control of their own health and wellbeing. Many of those who had failed to progress were seen as having taken part because they felt it was expected of them, rather than having a genuine interest.

The quality of the therapeutic relationship between the customer and the CMP practitioner was also argued to be crucial in helping people to move forward. At its best it was seen to offer opportunities to discuss issues in confidence and in depth and enable people to learn new techniques and perspectives for managing their condition. People with anxiety, depression and back pain were seen to have derived particular benefit from CMP. Some practitioners felt that, for people who had been away from the labour market for a long period, the discipline and structure provided by being expected to turn up for a group at the same time each week was at least as important as anything substantive which was discussed.

Relationships between individual jobcentres and CMP seemed to thrive where there were maximum opportunities for regular informal feedback and discussion, i.e. where CMP staff were located in the jobcentre or had a base there several days a week. Although this could cause a degree of isolation for individual workers, who needed to ensure that they received adequate peer support and clinical supervision, it was regarded as paying dividends in increasing the rate and suitability of referrals.

6.4 Service gaps and suggestions for improvement

Few of those interviewed identified major gaps in service provision, although these were mentioned in respect of substance abuse, customers with ME and those with diabetes and neurological conditions. Practitioners generally felt that the needs they were not able to meet were well provided for by other local statutory and voluntary services in their area. Several practitioners commented on the fact that they had needed to adapt their services on an ongoing basis in order to respond to customer needs. For instance, in one area, cognitive behavioural therapy (CBT) provision was centred on the use of a standardised workbook, but customers had disliked these, finding them too reminiscent of school and the language and concepts alienating, and it had been necessary to develop more accessible tools.

People from ethnic minorities, especially those with ESOL needs, were also felt not to be well served at present. In one area, a bilingual practitioner had been employed but take-up remains low. This was felt to be primarily an issue about increasing awareness of CMP via publicity and outreach, but also implies a need to invest in services to meet language and cultural needs.

Not all CMP providers were content to refer out specific issues, such as debt counselling. This was because they wanted to provide an holistic service, and because they were aware that there were pressures on other local agencies, which might lead to a customer not getting the help they needed. Some Primary Care Trusts (PCTs) were, therefore, seeking additional funding to offer services such as debt counselling and relationship counselling as part of CMP.

6.5 Advice for Condition Management Programme services in new pilot areas

Those delivering and managing CMP in the original seven pilot areas are being twinned with new areas as they develop their services. As part of this study, they were asked for their thoughts regarding the task facing the next 14 areas, and for specific advice that they would offer based on their own experiences. This section discusses those comments.

A key point made by several practitioners was the importance of **clarity about what is being proposed**, both within the CMP team, and in terms of promoting it to outsiders. In communicating with Jobcentre Plus, it was felt vital to give examples of the types of customers who should and should not be referred, although CMP practitioners varied in how rigidly they wished such distinctions to be drawn.

One manager suggested that it was important for new CMP services to do thorough research into what already exists within the relevant PCTs and to **develop services based on existing models of good practice**, rather than seeking to create something entirely new. A related point, made by those with experience of contracting out provision, was that it was helpful to concentrate on **working with a limited number of providers with specialist expertise** to contribute, for ease of management.

Staffing was felt to be crucial by a manager who had been forced to deploy new recruits in face-to-face work within a week of their start date. Given the time it takes to recruit suitable staff, it was argued that it was vital to start getting people in post as soon as the broad outline of provision had been decided. There was also perceived to be a longer-term need to **make working on CMP more attractive to potential recruits**. Problems recruiting in some areas were attributed to the fact that CMP was a rather unknown element, and people were not sure how it would contribute to their career development, and there was also a perceived lack of career structure for those who now wish to remain with CMP over the longer term.

Interviewees highlighted the need for **appropriate infrastructure and communication protocols** (including email facilities and accommodation, as well as customer referral and tracking systems) to be set up as quickly as possible, to ensure that CMP was effectively networked with Jobcentre Plus and able to work in an efficient and mutually supportive way. Those with contracted out provision felt that the incentive structure for **quality control issues** needed to be strengthened in some way.

Networking with local agencies was seen as vital to avoid duplication, raise awareness about CMP locally, and ensure that customers had access to appropriate services. One CMP service which had not initially realised the importance of meeting other stakeholders in the area found that it had to invest a considerable amount of time in ad hoc development work at a later stage, and advised others to be more proactive in this respect. The point was also made that it was important to review involvement in networks and meetings. One CMP service which had initially attended a large number of local forums had scaled back their commitments when they realised that the costs, in terms of staff time, were no longer proportionate to the benefits.

The importance of **effective marketing of CMP** was also emphasised. Some of those in the original pilot areas felt this was an issue they had come to quite late in the day, because of the energy they had expended in designing and setting up their provision, and they felt that new areas could benefit by addressing this at an earlier stage. Some practitioners also felt that they were badly let down by the publicity materials available in their areas, commenting that poorly produced leaflets did not convey the positive and professional image they wanted to get across.

The level of **resources for CMP** was felt to be important. The additional time available for customers, and the fact that services could be tailored to meet individual needs, were seen as key factors in CMP's success in meeting customer needs. At a strategic level, it was also felt important that managers and practitioners had sufficient resources to be able to work reflexively, developing the services offered in the light of experiences to date. There were some concerns that future levels of resourcing for CMP might be less generous and that this could be detrimental to the development and effectiveness of new services.

Finally, those delivering CMP urged those about to embark on this task to have confidence that they could make a difference, and in their ability to help customers improve their health status and employability.

Appendix A Condition Management Programme manager topic guide

Pathways to Work evaluation

CMP STUDY: DEPTH INTERVIEWS WITH CMP MANAGERS

Research objectives:

- **Exploring the role of the CMP manager within the IBR (including changes over time to the role); mapping the range of advice/support and guidance they offer**
- **Examining the relationship they have with PAs/job brokers/ employers/GPs, other agencies**
- **Exploring what works and any difficulties/constraints faced by the CMP provider in performing their role effectively**

1. Introduction

- Introduce self, the evaluation and organisations involved (Natcen, SPRU, PSI)
- Stress independence of evaluation from DWP
- Explain about confidentiality
- Explain about tape recording and length of discussion
- Ask to sign consent form

2. Background information

- Can you tell me about your role?
- What does it involve?
- How long have you worked in this job?

  Probe re:

  - Nature of employment within CMP (i.e. secondment, recruited from outside, etc.)
  - What stage of development was CMP when you joined – were you there from the outset?
- What attracted them to the position?

  Probe re:

  - Specialism and interests
- Previous work experience (in particular in working within the field of occupational health/vocational rehabilitation, any experience of working with Jobcentre Plus before)

3. Understanding of CMP and its role in the IB reforms

- How heard about IB Reforms and CMP? Ask whether they had been involved in delivering similar provision before or whether such provision exists e.g. is CMP new?
- First reactions to idea? Expectations?
- Views on approach being adopted?
- Views about what CMP would add to Pathways to Work package

  Probe re:

  - Links between health, provision and employment
  - Expectations around types of customers CMP would be able to help and why in terms of distance from work, barriers, health conditions

4. Organisation of CMP

[some of this information may have been provided in co-ordinator telephone interview, questions to be asked at interviewer discretion]

- How is CMP organised in your district? (probe re: in-house, contracted out or mixture?)
- Rationale for organisation described
- **Only where more than one PCT involved:** How much experience had the PCTs in working together before CMP? How easy to identify lead PCT? What criteria were used

- How easy was it to recruit suitable workers? How they went about recruitment, whether some posts were easier to fill than others and why
- What sort of skills/experience were you looking for in recruiting staff? And what sort of induction is provided to build on their skills?
- Have there been any issues regarding pay differentials (i.e. between clinical specialisms, seconded vs others?)
- Have there been any retention issues?
- Have there been any changes in how CMP is organised over time?

  Probe re:

  - Reasons for change, whose idea to change?
  - How has change improved service?
  - Any problems/issues?
- Can you tell me some more about the particular provision you are involved in delivering?

  Probe re:

  - Types of services offered to customers- i.e. generic or based on the three main conditions, any other services offered
  - Location/s (e.g. job centre surgeries, are home visits made?)
  - (size of)Group/one-to-one
  - Length of time/flexibility
  - How does this provision compare with other similar provision you have experience of?
- Are there any gaps in provision?

  Probe re:

  - What kind of impact is this having on customers and outcomes?
  - Have they tried to fill any gaps, how, progress
  - Is there any perceived duplication with other providers offering similar provision – what has been the effect?
- What do you feel are the advantages and disadvantages of qualified health clinicians providing CMP, as opposed to generic workers or IBPAs?

(**only for managers in contracted-out, or part contracted-out provision**)

- How did you go about recruiting providers?
- How happy are you with the quality and availability of what is being provided? How were they developed? E.g. based on existing standards within the PCT.

- Do you have quality standards? What are they? Who monitors? What is the feedback/complaints procedure? Are there common quality standards across the 7 CMPs – if not why not? What would be the advantages/disadvantages?
- Any problems/issues, suggestions for improvements?
- Have there been any problems running CMP within your PCT – e.g. issues about standards etc.?
- What does CMP add that other existing services (either health or employment) couldn't provide?

5. Experiences of working Jobcentre Plus

- Can you tell me about how you work with jobcentres?

  Probe re:

  - Which District/Jobcentre Plus offices do you have contact with?
  - Which staff do you have most contact with?
  - Do you work in the same way with all of them?
  - Examples of the way they work – e.g. regular days when attend
  - Jobcentre, joint interviews? Any regular meetings?
  - Whose idea were these ways of working?
  - How CMP is introduced to IBPAs/other Jobcentre staff (i.e. formal training, case conferencing, organised tours, sit ins on sessions with customers)
  - Perceptions of levels of understanding amongst IBPAs and other Jobcentre staff re. CMP service provision, and reasons (how could these be improved further?)
  - Key messages given to Jobcentre staff regarding the role of CMP providers and the type of customers they can deal with
  - Do you stay in touch with Jobcentre Plus/PAs while working with a customer who has been referred? How, and how often? How much does this vary between offices or PAs?
  - Who instigates the contact? Does Jobcentre Plus also get in touch? How much does the PA stay in touch with you?
  - How they manage the end of a customer's contact with CMP, nature of contact with IBPAs at this point

- How well are these arrangements working?

  Probe re:

  - Any problems/issues? How resolved? (have there been differences in culture that have made working together difficult, what about bureaucracy?
  - Are the referrals you are getting appropriate? (explore change over time) Where these are not appropriate why not? Too severe, not motivated?

- Whether they are they getting the number of referrals they were expecting
- Suitability of customers for CMP in terms of distance from work, health condition What proportion of customers are found to be unsuitable for CMP at the initial assessment?
- Knowledge of how many customers turn down CMP/fail to attend – views about why (i.e. way that it is 'sold' by IBPA, customer type, accessibility issues etc.)
- How do you review whether it is working for both parties?
- If not working well, how do you resolve?
- Suggestions for improvements?
- Do you have any previous experience in working with Jobcentre Plus e.g. with DEAs – if so, how have things changed?

6. Experiences of working with NDDP job brokers

- What sorts of contacts/relationships, if any, do you have with NDDP job brokers?

  Probe re:

  - Which ones, who initiated, importance?
  - Are you referring to NDDP or accepting referrals via Job Brokers? What are the circumstances under which such arrangements are happening? How well do they work?
  - Do you attend local Job Brokers network meetings?
- Change over time?
- Any problems/issues, suggestions for improvements? Have problems been resolved? How?

7. Experiences of working with employers

- What sorts of relationships, if any, do you have with employers?

  Probe re:

  Which employers, who initiated, importance?
- Change over time?
- Any problems/issues, suggestions for improvements?

8. Experiences of working with other agencies

- What other organisations (other than NDDP) have you had contact with (Welfare organisations, training providers?
- Under what circumstances do they get in contact with you – or you need to contact them? How are working relationships developing?
- To what extent do you use your experience of CMP to persuade GPs of the benefits in terms of health improvements?

- Do you have direct contact with the GPs of those on CMP? Do you have wider networks where you can sell the benefits of CMP to GPs?
- What about other health professionals within your PCT?

9. Satisfaction in role

Recap on expectations outlined in section 3 if necessary

- Has the role been as you expected it?

  Probe re:

  - Job satisfaction
  - Best/worst aspects of job?
- What's the most important bit of advice you'd give to someone starting to manage/deliver CMP in a new area? Why?

10. Added value of CMP and suggestions for improvements

Recap on any gaps in provision mentioned in section 4

- Overall views about what CMP programme adds to the IBR package How could CMPs be developed further to support the overall aims of Pathways?
- Would your programme be suitable for people at risk of losing their job because of a recently development illness or disability (i.e. as a retention/rehabilitation package)?
- Do you have evidence of your programme helping someone retain a job through your support? (i.e. the in-work support provided after the initial sessions to prepare for work).
- Suitability of CMP set-up for types of customers they are working with
- Are there any other changes you would like to see? (i.e. in terms of format, location, intensity and timing of provision)
- Explore issues re team dynamics, recruitment and retention, if not already raised.

  Probe re:

  - Have there been any issues concerning poaching staff from similar initiatives? What has been the knock on effect of other PCT services as staff are drawn into CMP and vice versa?
- How important is the CMP managers network in the development of your CMP – has it been useful for resolving problems? Are there any tensions?
- How important has the relationship been with your Pathways District Implementation Manager?
- What experience have you had to date with 'selling' CMP to those not currently involved (are you twinned with one of the next 14 areas in the Pathways expansion for example) – what messages would you pass on?

Thank respondent for their time and remind about confidentiality. Explain how findings will be used.

Appendix B Condition Management Programme provider topic guide

Pathways to Work evaluation

CMP STUDY: DEPTH INTERVIEWS WITH PRACTITIONERS

Research objectives:

- **Exploring the role of the CMP provider within Pathways to work (including changes over time to the role); mapping the range of advice/support and guidance they offer**
- **Examining the relationship they have with PAs/job brokers/ employers/GPs/other agencies**
- **Exploring what works and any difficulties/constraints faced by the CMP provider in performing their role effectively**

Note: Interviewer to use discretion/avoid duplication of existing information in questioning.

1. Introduction

- Introduce self, the evaluation and organisations involved (Natcen, SPRU, PSI)
- Stress independence of evaluation from DWP
- Explain about confidentiality
- Explain about tape recording and length of discussion, consent forms.

2. Background information

- Can you tell me about your role?
- What does it involve?

  Probe re:

  - experience and interests (esp. relating to vocational rehabilitation)
  - (including e.g. geographical/health area covered)
- How long have you worked in this job?

  Probe re:

  - Nature of employment within CMP (i.e. secondment, recruited from outside, etc.)
  - What stage CMP at when joined (in at the start?)
- What attracted them to the position?
- Previous work experience, clinical/medical qualifications
- Clinical specialist (what specialism?) or generic CMP practitioner/voluntary sector provider?

3. Understanding of CMP and its role in the IB reforms

- How heard about IB Reforms and CMP?
- First reactions to idea? Expectations? Aware of/delivered any similar provision before?
- Views about what CMP would add to Pathways/Choices package

  Probe re:

  - Expectations around types of customers CMP would be able to help and why in terms of distance from work, barriers and health conditions
- How is CMP organised in your district? Rationale for organisation
- Have there been any changes in how CMP is organised over time?

  Probe re:

  - Reasons for change, whose idea to change?
  - How has change improved service?
  - Any problems/issues?
- Can you tell me some more about the particular provision you are involved in delivering?

Probe re:

- Location/s (e.g. job centre surgeries, are home visits made?)
- (size of)Group/one-to-one
- Length of time/flexibility
- Gaps in provision

- What do you feel are the advantages and disadvantages of qualified health clinicians providing CMP, as opposed to generic workers or IBPAs?

4. Experiences of working with IB customers

(may not be involved in direct work with customers, in which case, skip to next section)

- Types of customers they are working with in terms of distance from work, barriers and health conditions, views about suitability of these customers for CMP
- How do customers find out about CMP?
- What are their expectations when you first meet them?

Probe re:

- Origin of expectations (i.e. what they are told by IBPA/other source)
- Understanding of how CMP can help them
- Views on whether expectations are appropriate
- Whether understand voluntary not mandatory
- (How) do these change over time?
- What aspects of CMP are customers most interested in? Does this change over time?

- Do many people drop out? Do you have a sense for their reasons?
- Are any customers referred back to IBPAs for more appropriate referral and why? Are customers counselled out?

Probe re:

- Any pattern evident in customers referred or counselled out in this way?
- Awareness of what happens to these customers?

- Whether had customers who start CMP but have to leave because IB is withdrawn?

Probe re:

- Frequency with which this happens, how feels about this?

- How do you talk to customers about their condition?

Probe re:

- Whether discuss in context of employment?

- Whether discuss in relation to demands of specific job, their own most recent job?
- Whether get involved in jobsearch?
- What sorts of changes do you see in customers over time?
- What do you count as an outcome?
- How are you tracking customer progress? Do you have a database? How do you share information with Jobcentre Plus and provide feedback to IBPAs about customer progress?
- Position of customers at end of contact with CMP in terms of readiness to work/ ability to manage health condition/ general confidence levels. Able to 'map' different positions and explain reasons behind them?
- What have you found to be most effective in working with customers and why?

  Probe re:

  - Examples of successful outcomes – details of both customer, and intervention
  - Views about key factors affecting positive outcomes
- Are there any groups you find it harder to work with?

  Probe re:

  - Examples
  - Reasons
  - PCA and appeals
  - People who don't get work
- Suitability of CMP provision for types of customers they are working with, whether are any changes would like to make (i.e. in terms of format, location, intensity and timing of provision)
- Knowledge of how many customers turn down CMP/fail to attend – views about why (i.e. way that it is 'sold' by IBPA, customer type, accessibility issues etc.)
- Lessons learnt from experiences

5. Experiences of working with Jobcentre Plus

- Can you tell me about how you work with Jobcentre Plus?

  Probe re:

  - Which Jobcentre Plus offices do you have contact with?
  - Which staff do you have most contact with?

- Do you work in the same way with all of them?
- Examples of the way they work – e.g. regular days when attend Jobcentre Plus office, joint interviews? Any regular meetings?
- Whose idea were these ways of working? Any issues re different cultures, bureaucracy? Whether/how resolved?
- How CMP is introduced to IBPAs/other Jobcentre Plus staff (i.e. formal training, case conferencing, organised tours, sit ins on sessions with customers)
- Perceptions of levels of understanding amongst IBPAs and other Jobcentre Plus staff re. CMP service provision, and reasons
- Key messages given to Jobcentre Plus staff regarding the role of CMP providers and the type of customers they can deal with?
- Do you stay in touch with Jobcentre Plus offices/PAs while working with a customer who has been referred? How, and how often? How much does this vary between jobcentres or PAs? Who takes the initiative regarding contact?
- How they manage the end of a customer's contact with CMP, nature of contact with IBPAs at this point

- How well are these arrangements working?

  Probe re:

  - Any previous work with Jobcentre Plus, e.g. with DEA – how does it compare?
  - Any problems/issues? How resolved?
  - Are the referrals you are getting appropriate? (explore change over time) – possible to quantify proportion of those found unsuitable at initial assessment?
  - Whether they are getting the number of referrals they were expecting
  - Suitability of referrals for CMP in terms of customer distance from work, barriers, health condition, explanations for suitability/unsuitability
  - How do you review whether it is working for both parties?
  - If not working well, how do you resolve?
  - Suggestions for improvements?

6. Experiences of working with NDDP job brokers

- What sorts of relationships, if any, do you have with NDDP job brokers?

  Probe re:

  - Which ones, who initiated, importance?
- In which direction are referrals? CMP to job broker, or vice versa?
- Attending local Job Brokers network meetings?
- Change over time?
- Any problems/issues, whether/how resolved, suggestions for improvements?

7. Experiences of working with employers

- What sorts of contact/relationships, if any, do you have with employers?

  Probe re:

  - Which employers, who initiated, importance?
- Change over time?
- Any problems/issues, suggestions for improvements?

8. Working with other agencies

- What other organisations (other than NDDP) have you had contact with (Welfare organisations, training providers?
- Under what circumstances do they get in contact with you – or you need to contact them? How are working relationships developing?
- To what extent do you use your experience of CMP to persuade GPs of the benefits in terms of health improvements?
- Do you have direct contact with the GPs of those on CMP? Do you have wider networks where you can sell the benefits of CMP to GPs?
- What about other health professionals within your PCT?

9. Satisfaction in role

- Has the role been as you expected it?

  Probe re:

  Any surprises?

  Job satisfaction

  Satisfaction with pay

  Best/worst aspects of job?

10. Overall views and suggestions for improvements

Recap if necessary

- What's the most important bit of advice you'd give to someone starting to deliver CMP in a new area? Why?
- Overall views about what CMP programme adds to the Pathways/Choices package
- Key ways in which CMP makes difference to customers
- How could it be developed to increase its effectiveness?
- Suitability for someone at risk of losing job (retention issues), aware of anyone retaining a job because of their intervention?
- Is there any provision you would like to have available, but don't?
- Are there any other changes you would like to see?

Thank respondent for their time and remind about confidentiality. Explain how findings will be used.

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