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Provider-led Pathways: experiences and views of Condition Management Programmes

by Katharine Nice and Jacqueline Davidson

Department for Work and Pensions

Research Report No 644

Provider-led Pathways: experiences and views of Condition Management Programmes

Katharine Nice and Jacqueline Davidson

A report of research carried out by the Social Policy Research Unit (SPRU),
University of York on behalf of the Department for Work and Pensions

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Summary

Introduction

This report presents the findings from a qualitative study carried out in 2009 exploring the experiences of people supplying and using Condition Management Programme (CMP) services within the Provider-led Pathways programme. The study was commissioned by the Department for Work and Pensions (DWP) and was led by the Social Policy Research Unit, working with the National Centre for Social Research.

Condition Management Programmes were established as part of the Pathways to Work pilot, as an innovative intervention designed to help people understand and manage their health conditions in preparation for returning to work. Provider-led Pathways contracts stipulate that providers must offer some form of Condition Management Programme, though there is a degree of freedom in how these programmes are designed and delivered.

This research study was designed to provide an understanding of how CMP is operating in Provider-led Pathways districts. The research was carried out in four districts and generated data from the following key stakeholders: 10 Pathways managers who oversee CMP provision, and managers within contracted out CMP provision; 15 Pathways advisers who refer people to CMP; 14 CMP practitioners and 36 CMP clients.

Organisation and structure of the CMP programmes

In keeping with the 'black box' model of implementation, the organisation and structure of CMP varied over the four study areas. Areas differed on a number of key structural and operational elements of CMP provision which might be expected to have an impact on how provision is experienced.

Two of the providers contracted out their CMP provision, while providers in the other two areas provided theirs in-house. In some areas, CMP staff shared office space with Pathways staff. There were also differences in the qualifications and

experience of staff who were recruited to deliver CMP and this made a difference as to whether CMP practitioners were able to offer therapeutic or non-therapeutic interventions. At the time of the research study, some providers were experiencing some problems with staff recruitment and retention.

The content and format of CMP sessions also varied across the different areas. Some programmes only provided either group sessions or individual CMP sessions. In other areas, both types of sessions were available for clients to choose from. In some areas, CMP content had been designed to focus on a range of physical and mental health conditions and in others, the programme's primary focus was on mental health. Some providers had chosen to deliver generic content in CMP sessions while others sought to tailor support towards individual clients' needs.

Learning about CMP and the referrals process

Clients described learning about CMP in a number of different ways, from their Pathways adviser and other provider staff, from Jobcentre Plus staff, from leaflets sent by the Pathways provider through the post and from people in their social networks. There were no set procedures followed by Pathways advisers regarding when they told clients about CMP and advisers' approaches also differed regarding which clients they **told about** CMP and which clients they **referred to** CMP.

A range of positive responses were reported by clients on hearing about CMP. Clients were found to have varying understandings about the nature of CMP. Some had thought the programme would focus on helping them learn more about improving and managing their health conditions and some had also understood that this would enable them to find paid work at some point in the future. Clients' reasons for participating in CMP included wanting to get well and (back) into a 'normal' routine, wanting to get (back) to paid work and wanting help with their health condition(s). Some clients had not understood that their participation in CMP had been voluntary and had thought that they had no choice but to participate in the programme, which was also supported by the data from CMP practitioners. Practitioners also thought that some clients had come to them with unrealistic expectations about what CMP could deliver.

The referrals process had worked well for some clients, but others had experienced delays in accessing CMP provision, which were considered to be disappointing where people were very keen to access provision. CMP practitioners in some areas reported that there could be up to a two month waiting list for joining the programme, in part due to staff shortages and also a lack of adequate space in CMP premises. Pathways advisers reported that clients could lose trust in them and motivation declined when they had to wait a long time to participate in CMP.

The physical proximity of Pathways advisers and CMP practitioners could be seen to affect how clients were referred, with CMP staff situated in provider offices on hand to help assess some clients' suitability for CMP. CMP practitioners reported a range in the depth of information handed on by advisers about clients referred to the provision.

Some Pathways advisers and CMP providers thought that some advisers were sometimes referring people for CMP for whom the provision was not appropriate (for example people with severe mental health conditions, or people who had not received a diagnosis for their condition).

Experiences of CMP delivery

Despite the different ways in which CMP was designed in the study areas, people reported a number of key elements common to their experiences of CMP delivery. Sessions were described as including an introduction from staff, a chance to explore clients' problems and information about their health conditions.

CMP staff behaviour and expertise in sessions were seen by all concerned as being crucial to client engagement. While there was evidence that individually tailored support was particularly helpful, this did not mean that group workshops were unhelpful, as they were perceived as providing opportunities for people to meet others in similar circumstances and as encouraging mutual support between group members.

Unhelpful aspects of CMP delivery included sessions being held in inappropriate locations and buildings. This could mean that some people had far to travel, or that rooms were too small or lacked soundproofing facilities and were noisy or did not protect privacy as a result. There was evidence that CMP did not meet everyone's needs, for example where people had severe health conditions or multiple barriers to work, or where their health problems were primarily physical. Negative interactions with staff and uncertainty about staff expertise and the validity of the 'therapeutic' approaches they adopted were also highlighted as unhelpful aspects of CMP.

CMP staff differed in the extent to which they focused on work within CMP sessions. Some had a distinct and constant focus on paid work where others introduced work when this seemed appropriate for the individual client. The extent to which clients acknowledged the same strength of focus on work, and responded positively, seemed to depend on how motivated they were to return to work. For example, people who were looking for work-oriented support were happiest when work seemed the main focal point of CMP sessions.

Non-attendance levels were a concern in all of the study areas. Findings from CMP practitioner and client data showed that non-attendance could be explained by a range of factors, including individuals' attitudes (such as a lack of motivation) or circumstances (such as deteriorating health), CMP structure and delivery (for example, long waiting lists or finding session content irrelevant) and external barriers (such as travel problems).

CMP managers and practitioners described various forms of staff support and supervision, which was found to be particularly helpful where staff were dealing with a range of clients' circumstances, where there was open access to managers, and where colleagues were able to support each other.

Linking CMP to other Pathways services and support from other sources

There was variation in whether Pathways advisers attempted to continue clients' work-focused interviews during the time they were taking part in CMP. Some advisers perceived that they were not allowed to defer work-focused interviews, even if this meant they could combine interviews with client progress made on CMP, while other advisers felt able to defer interviews as appropriate.

For some clients the ending of their CMP sessions were emotionally upsetting, especially where their sessions terminated early and they had little notice of this, for example when CMP practitioners left their employment. Comparing CMP across the four different areas in this study suggests that the structure of CMP can affect the degree to which clients could experience the ending of CMP as either more or less 'sudden'. For example, the least abrupt ending to CMP seemed to occur where modules had been designed to run on for long or indefinite periods, such as Pilates sessions that were operated on a drop-in basis.

There were differences in how, and if, clients were referred back to Pathways Advisers by CMP practitioners after CMP sessions had finished. In one area, three-way meetings between the client, adviser and CMP practitioner were perceived as useful for agreeing the next steps to be taken by the client.

Physical proximity between CMP providers and Pathways advisers was important in a number of different ways, especially in working relationships, communication, and an understanding of the respective roles between Pathways advisers and CMP practitioners. Practitioners said that they worked with advisers in order to 'up skill' them for their dealings with clients: for example, educating advisers about who to signpost to other organisations.

Some CMP clients were immersed in strong social and health-related networks, but others were found to have had virtually no support from any other sources. For those with little or no support outside of Pathways and CMP, other organisations and services that CMP practitioners (and advisers) could signpost them to are potentially important. However, some CMP practitioners spoke of the difficulties encountered in signposting CMP clients. These included the limited availability of low cost or free counselling services, and problems identifying information about appropriate local services.

Views on the impact and performance of CMP

Managers' and practitioners' views about CMP performance were generally positive even though most providers were in the early stages of developing performance targets and measuring outcomes.

For some clients, attending CMP had helped to initiate and enhance their progress towards paid work, such that some had taken steps towards work such as searching

for jobs, taking up training or gaining paid employment. For many, CMP had resulted in increased confidence and motivation which along with learning more about how to manage their health conditions (and sometimes seeing symptoms improve) seemed to help people to feel more ready for work. Even for those people considered to be furthest from paid work, improvements in well-being could be achieved, which were regarded by staff as a first step in removing barriers to work.

CMP was not able to help all clients, however. Some clients said that participating in CMP had made no difference to them, or that the impacts made were limited or negative. It also appeared that personal circumstances (such as deteriorating health conditions) and certain aspects of delivery (for example, the content of CMP sessions seeming irrelevant to them in their situation, or staff leaving employment with the provider) could obstruct the potential for CMP to influence progress towards work or improvements in well-being.

Analysis suggests that some CMP outcomes are typically longer-lasting (such as being able to control symptoms using practical techniques) in part because of service delivery methods (such as providing written information and advice that can be reviewed over time by clients). However, there were perceptions that where impacts were made during a short programme, or were not followed up with further support, these impacts could dissipate. In this respect, CMP helped people to make progress towards work or positive changes in their lives, but it did not often take people all the way to feeling ready for paid work.

Suggested improvements to operational and managerial matters within CMP included more staff, improved collaboration between Pathways and CMP staff, and more client information made available to practitioners at an earlier stage. Suggested improvements to the content and delivery of CMP sessions included the provision of more individualised support, more interventions targeted at physical conditions and provision of further support once CMP has ended.

Conclusions and discussion

This report has considered staff and participants' experiences and views of CMP within Provider-led Pathways. The findings show that CMP can help to improve people's well-being and readiness for work, notably through building confidence and motivation, and equipping people to self-manage their health conditions. However, there were also indications that some clients are not helped by CMP at present because the programme does not cater for their needs or because problems exist in aspects of delivery. The findings highlight the importance of the following aspects of delivery:

- ensuring Pathways advisers have a good understanding of the purpose and content of CMP and of what constitutes an appropriate referral;
- recruiting and retaining practitioners with excellent interpersonal skills and experience of working with people with health problems;

- providing opportunities for both individual support and group interaction as part of CMP;
- offering specific support for physical health conditions;
- ensuring clients are well supported after contact with CMP ends;
- developing collaborative ways of working between Pathways and CMP staff, and with external service providers.

In conclusion, the findings suggest that CMP is an essential part of Provider-led Pathways, by helping people make progress towards job readiness. On the whole the findings from this study were largely similar to those from studies of CMP within districts where Pathways is delivered by Jobcentre Plus (see Barnes and Hudson, 2006; Warrener *et al.*, 2009; Ford and Plowright, 2009).

1 Introduction

This report presents the findings from a qualitative study carried out in 2009 exploring the experiences of people supplying and using Condition Management Programme (CMP) services within the Provider-led Pathways programme. The study was commissioned by the Department for Work and Pensions (DWP) and was led by the Social Policy Research Unit, working with the National Centre for Social Research.

Provider-led Pathways refers to the final phase of the national roll-out of the Pathways to Work initiative that was first introduced in seven pilot areas and had been extended to 17 further districts by 2006. In all of these areas Pathways to Work was delivered by Jobcentre Plus on behalf of DWP. In 2007, DWP announced that the programme was to be extended to the remaining 31 districts in Great Britain, but in a departure from previous policy, services would be provided by a mix of private companies and third sector (i.e. voluntary, not-for-profit) organisations rather than Jobcentre Plus. Provider-led Pathways was implemented in two stages, in December 2007 and April 2008.

Condition Management Programmes were established as part of the Pathways to Work pilot, as an innovative intervention designed to help people understand and manage health conditions in preparation for returning to work. Provider-led Pathways contracts stipulate that providers must offer some form of CMP, though there is a degree of freedom in how these programmes are designed and delivered. This research study was designed to provide feedback from key stakeholders (Pathways managers, CMP managers, CMP front-line practitioners, Pathways advisers and CMP clients) in four locations, to understand how CMP is operating in Provider-led Pathways districts.

1.1 Policy and research context

Since its inception the Pathways to Work programme has consisted of a range of measures designed to help people move off incapacity benefits towards and into paid employment. These measures included:

- the requirement that claimants of incapacity benefits attend a series of work-focused interviews conducted by a team of Pathways advisers;
- a range of services and financial measures (together known as the 'Choices' package) to support progress to paid work. The **Condition Management Programme**, In-Work Support and Return to Work Credit were new measures introduced as part of Pathways to Work.¹

Provider-led Pathways provider organisations have been given a substantial degree of autonomy in how they choose to deliver the Pathways to Work programme, known as a 'black-box' contract. The contracts between DWP and provider organisations do have some stipulations however, which require that providers carry out a series of work-focused interviews with clients and provide tailored, work-focused support alongside a personal action plan. Providers also have a contractual duty to include in their range of interventions a CMP. CMPs should focus on at least the three main health conditions that have given rise to the majority of Incapacity Benefit and Employment and Support Allowance claims, i.e. musculoskeletal, cardiovascular and mild to moderate mental health conditions.

CMP is a joint venture between the Department of Health and DWP in districts where Pathways is delivered by Jobcentre Plus. The programme is based on a bio-psycho-social model of health and illness and provides clients with information and advice to help them overcome barriers, such as anxiety and lack of confidence, and to manage health conditions in work. It is not the aim of CMP to offer clients treatment for their health conditions but rather to empower them by educating about what they might be capable of despite their health condition(s).

A number of research studies have been conducted exploring experiences of Condition Management Programmes within Jobcentre Plus-led Pathways. The first study, commissioned by DWP, took place during an early stage of implementation and involved CMP practitioners, co-ordinators and managers in the original seven Pathways to Work pilot areas (Barnes and Hudson, 2006). Another DWP study, conducted in three Jobcentre Plus districts with 30 CMP participants, sought to deepen understanding of clients' experiences and views of CMP (Warrener *et al.*, 2009). A third study was commissioned by the Department of Health and aimed to assess the impact achieved by CMP (in the seven Pathways pilot areas) on participants' health and readiness for work, and on the local health and social care economies (Ford and Plowright, 2009). Findings from these studies helped to inform the design of this study. These findings are also used in a discussion of conclusions and implications in Chapter 7 of this report, to draw comparisons between CMP provision in Provider-led Pathways areas and areas where Pathways to Work is delivered by Jobcentre Plus.

¹ These measures run alongside previously established support such as the New Deal for Disabled People, access to a Disability Employment Adviser, WORKSTEP, Access to Work and Residential Training Colleges.

1.2 Research aims and questions

The overall aim of the study was to generate data about the experiences of people delivering and using CMP services, to learn lessons of effective practice and to identify potential difficulties and how these are being addressed. To meet the study objectives, a number of topics were explored with each of the key stakeholders.

For Pathways managers who oversee CMP provision, and managers within contracted out CMP provision:

- the design of CMP delivery;
- the volume and appropriateness of referrals to CMP;
- the processes involved in monitoring performance and supporting staff;
- the importance and quality of relationships with Jobcentre Plus/DWP, with the Pathways provider or sub-contractor (as appropriate), and with other organisations;
- their overall reflections on the delivery and impact of CMP.

For Pathways advisers who refer people to CMP:

- their knowledge about CMP;
- their approaches to introducing CMP, client responses and take-up, and the process of making referrals to CMP;
- the level and nature of contact with clients and CMP staff after referral;
- their overall reflections on the delivery and impact of CMP.

For CMP practitioners:

- experiences of receiving referrals including perceptions of the appropriateness of referrals;
- experiences of delivering CMP interventions and what happens at the end of the programme;
- (where sub-contracted) views on relationships with Pathways provider staff;
- the availability of staff support and the ways in which staff are supervised;
- their overall reflections on the delivery and impact of CMP.

For CMP clients:

- their experiences of learning about CMP and their initial impressions;
- their experiences and views of attending CMP sessions;
- whether they had received any significant support from other sources since being referred to CMP;
- their reflections on any impacts that CMP had made.

1.3 Research design and methods

The research questions were designed to elicit peoples' experiences and perceptions of CMP and so required the use of qualitative data collection and analysis techniques. Fieldwork was carried out in four locations in the UK. Information supplied by DWP showed that, in keeping with a 'black-box' approach to administration, some Pathways providers were delivering CMP through in-house teams (for example, of occupational therapists) while others had contracted out their CMP provision. Therefore, the research study included two areas where CMP was provided by in-house delivery and two areas where CMP was sub-contracted.

The study was conducted in three main phases:

- a scoping exercise in each location, involving Jobcentre Plus third party provision managers and CMP managers, which aimed to provide information about CMP delivery arrangements and to identify key personnel for research interviews;
- individual and group interviews with Pathways and CMP staff
- individual interviews with CMP clients.

A more detailed explanation of the research methods and analysis adopted by the study can be found in Appendix A.

The main characteristics of the achieved sample are presented below in Tables 1.1 and 1.2. More detail can be found in Appendix A.

Table 1.1 Achieved interviews across four fieldwork sites

	Type of interview	Number of people
In-house CMP managers	Individual or paired	4
Pathways provider CMP managers (where CMP is sub-contracted)	Individual or paired	3
Sub-contracted CMP managers	Individual	3
Pathways advisers	Group	15
CMP practitioners	Individual or group	14
CMP clients	Individual	36

In the original study design, it was expected that CMP clients would be recruited using a database extract supplied by DWP, which would list everyone referred to CMP between November 2008 and January 2009. Using this information, the researchers hoped to recruit 36 people with diversity in primary health condition, gender and age. However, problems accessing this data meant that an alternative method for recruiting CMP clients was sought. Thus, providers were asked to supply a list of the 50 most recent CMP attendees from their own records, which then formed the basis for recruitment. Using information about client characteristics (where this was available), a purposive sample was selected to provide a mix of ages and a roughly equal proportion of men and women. It was expected that

variation in health conditions and length of time on CMP would be found among the achieved group of participants without sampling for it. Table 1.2 sets out the main characteristics of the CMP client sample

Table 1.2 Main characteristics of the CMP client sample

Main characteristics	Number
Gender	
Women	20
Men	16
Age	
18-29	4
30-49	18
50 plus	14
Self-reported health conditions	
Musculoskeletal	12
Mental health	27
Cardiovascular	0
Other	20
Stage reached in CMP	
Assessment only	1
First session only	1
Mid-way through	15
Ended part-way through	4
Programme finished	15

The resulting data were analysed systematically using the data management technique *Framework* (Ritchie and Spencer, 1994). A thematic framework was developed for the classification and summary of the data from interviews according to the themes emerging. This approach meant that the analysis was grounded in participants' own accounts and, at the same time, enabled analysis to address key policy interests and issues.

1.4 Structure of the report

Chapter 2 draws on data from Pathways and CMP staff to describe the design of the Condition Management Programmes in the four research locations. It examines whether CMP was delivered in-house or sub-contracted, the interventions offered to clients, the levels of practitioner discretion and client choice, programme duration and a range of staffing issues. It also looks at managers' perceptions of the contractual requirements for delivering CMP and the ways in which CMP staff described the programme's purposes.

Chapter 3 looks at how clients came to learn about CMP and what they had initially understood as the aim of the programme. This chapter also considers the CMP referrals process and the perceived appropriateness of referrals from the perspective of clients, Pathways Advisers and CMP practitioners.

Chapter 4 explores experiences of CMP delivery from the perspectives of CMP managers and practitioners and CMP clients. In particular it covers experiences and views of the content and format of CMP sessions, the extent to which CMP focuses on work, non-attendance at CMP sessions and in-work support. The chapter also includes findings about clients' expectations for further CMP contact and staff experiences of support and supervision.

Chapter 5 considers how CMP links up with other Pathways services and how clients can be helped by other sources of support. In particular, the chapter explores Pathway adviser, CMP practitioner and client experiences of the end of CMP and contact between clients and Pathways advisers either during or after CMP. Clients' perspectives on other sources of support and CMP practitioners' experiences of signposting clients to other organisations are also examined. This chapter also discusses the working relationships between provider advisers and CMP practitioners.

Chapter 6 presents the views of Pathways advisers, CMP managers and practitioners and clients on the impact and performance of CMP. The chapter concentrates on the kinds and duration of impacts made by CMP on clients. Also included are findings regarding the methods for recording and measuring client outcomes, suggested improvements to CMP, and clients' ongoing barriers to work and support needs.

Chapter 7 concludes the report with a discussion of implications for policy and practice, drawing on themes that emerged in the study findings.

Appendix A provides a detailed explanation of the methodology used for the study and Appendix B reproduces the instruments used in data collection.

2 Organisation and structure of the Condition Management Programmes

Chapter 2 sets out the design of the Condition Management Programmes (CMP) in the four locations studied. First, managers' perceptions of the contractual requirements for delivering CMP are reported in Section 2.1 before Section 2.2 considers the ways in which CMP staff describe the programme's purposes. Using CMP manager and practitioner interview data, a full examination of the design of CMP in the four study areas is provided in Section 2.3, looking in detail at whether CMP was delivered in-house or sub-contracted, the interventions offered to clients, the levels of practitioner discretion and client choice, programme duration and a range of staffing issues. The chapter concludes in Section 2.4 with a summary of the main findings.

2.1 Contractual requirements

All of the CMP managers at Pathways providers and sub-contractors were asked to explain their contractual requirements for delivering CMP. Pathways provider CMP managers referred to the contract that they hold with the Department for Work and Pensions (DWP) to deliver the Pathways to Work programme, which includes a requirement to provide a CMP. The 'black box' contract gave Pathways providers a free rein to design a programme that focused on at least the three main conditions that give rise to the majority of Incapacity Benefit and Employment and Support Allowance claims (i.e. musculoskeletal, cardiovascular and mild to

moderate mental health conditions) and which conforms to clinical governance standards and data protection requirements.²

Given this design freedom, it might be considered surprising that some CMP managers of Pathways providers referred to aspects of delivery as contractually agreed, such as the format of sessions (i.e. one-to-one sessions and/or group workshops). One possible explanation for this apparent misunderstanding is that some managers had confused contractually agreed terms with decisions that had been informally discussed and agreed with DWP at other times. Aside from these perceived obligations, managers talked about requirements to provide a programme that was therapeutic in nature, using a multi-disciplinary approach, and aimed at helping people get back to work. Some managers explicitly referred to the requirement to meet clinical governance standards in the organisation and practice of CMP, or said that they were contractually obliged to employ healthcare professionals. There were, however, managers (some of whom had no clinical training or healthcare experience) who said they were uncertain about the role of clinical governance in the DWP contract. A recent development, explained by one manager, was that the provider had become contractually required to notify DWP when clients start participating in CMP.

Prior to this research study it was unknown what was stipulated in contracts between Pathways providers and CMP sub-contractors. The data suggests that in the three sub-contracts represented in this study, Pathways providers had comprehensive plans for the shape of CMP and passed on detailed obligations to their sub-contractors to realise their chosen design, such as the requirement to write individualised action plans and conduct a review at 13 weeks. The extent to which the requirement to uphold clinical governance standards had been explicitly delegated to sub-contractors seemed to vary. Thus some sub-contractor managers seemed to be aware of, if not responsible for, the inclusion of clinical governance standards in designing and implementing CMP. However, not all sub-contractors were able to say whether and how clinical governance played a role in CMP.

There was agreement among all the Pathways provider CMP managers that there were no performance targets relating specifically to CMP. In line with this, most Pathways providers did not impose job outcome targets on their sub-contractors, but sub-contractor managers had expectations about the number of people referred to them. However, one sub-contractor CMP manager explained how their contract had recently changed to include a target to move 15 per cent of CMP clients into paid work. Among Pathways provider CMP managers and sub-contractor CMP managers there were views that a job outcome target for CMP would give the programme an inappropriate focus and might motivate clinicians to act unethically. Managers seemed much happier to monitor and report 'soft' outcomes such as changes in confidence and reduction in symptoms of depression

² Where CMP is delivered in England it must conform to Department of Health Clinical Governance standards and data protection requirements. There are similar standards within Scotland and Wales.

or anxiety. Another contractual target mentioned by one sub-contractor manager was to ensure that practitioners were in contact with clients within ten days of referral. Non-contractual targets for staff performance are discussed in Section 6.1.

Some sub-contractor CMP managers explained the funding arrangements for the CMP contract. One funding model was to pay the sub-contractor an agreed price per referral or 'start' on the programme. To incentivise sustained engagement with the programme, one Pathways provider paid their sub-contractor part of the fee when the client started the programme and the remainder when they completed it. Another arrangement was to pay the contractor a set monthly fee based on expectations about the number of referrals, which made it imperative for the Pathways provider to meet their referral target to avoid losing money. At the time of the interviews, one sub-contractor was expecting to start being paid per course delivered rather than per referral as they were at present.

2.2 Description of CMP purpose

To understand practitioners' and managers' perceptions of the purpose of CMP they were asked to explain how they would describe the programme to someone who does not know anything about it, such as a potential client. Some responses to this question articulated the kinds of people who the programme was aimed at, such as people who have health problems and who are not working as a result, or people whose quality of life is poor due to ill health and who have subsequently 'lost their way'. Most people talked about what the programme aims to do and those most commonly cited can be grouped under three interlinked aims:

- helping people to understand their health condition(s), prognosis and treatment options and explore barriers to improved well-being;
- helping people manage their condition(s) to improve quality of life and ultimately take steps towards or into paid work;
- empowering people to manage their health condition(s) by raising awareness of coping strategies, such as enabling people to think differently, adjust to changing circumstances and focus on what they can do, and providing structure to daily living.

Other CMP aims identified by practitioners and managers were to help people reach appropriate specialist support, to help people identify what work they want to do and explain how being in work can contribute to feeling better, and to encourage and reap social benefits such as mixing with other people or undertaking voluntary work. Some people were keen to stress what CMP does not aim to do, such as provide cures for health problems. One manager explained that they did not deliver therapies because CMP was set up to enable and empower people, not to treat them. Against this, however, some talked about the importance of the therapeutic relationship between staff and clients and the particular 'psychological models'

applied. It was clear, therefore, that while some CMP staff felt the programme aimed to give advice and guidance, mentor, coach, encourage and enable clients, there were others who understood they were providing psychological support of a therapeutic nature.

2.3 CMP design

Not all the Pathways provider CMP managers in post at the time of the research interviews had been involved in the design of CMP. Those with knowledge of what had influenced the design explained how knowledge and experience from within the organisation had been useful or that external consultants had been drafted in to ensure the programme complied with clinical governance standards. The provider that was able to build on internal experience had previously trialed a programme similar to CMP for three years and had thus built knowledge about what works well. For sub-contractors, either CMP had been pre-designed by the Pathways provider, or sub-contractors had a role in designing their own programme working closely with the Pathways provider. The data is incomplete regarding views about these design arrangements, but there were signs that being given a pre-designed programme could be problematic where it was not accompanied with instruction for delivering some of the techniques and, as a result, practitioners' delivery could be inconsistent. In an area where this happened, CMP was later redesigned with greater input from the sub-contractor.

The sub-sections that follow set out the key, interlinked elements of programme design and draw out similarities and differences between the programmes in the districts studied. Table 2.1 summarises the approach taken in each area.

Table 2.1 CMP designs

	Area 1	Area 2	Area 3	Area 4	
In-house/sub-contracted	In-house	1 sub-contractor	2 sub-contractors initially. Only sub-contractor 2 continued contract after re-negotiations, which occurred prior to the research.	In-house	
Staff qualifications	Clinicians (including managers)	Clinicians/ community practitioners (including managers)	Community practitioners (including manager)	Clinicians/ community practitioners (including manager)	Clinicians (in-house managers not clinicians)

Continued

Table 2.1 Continued

	Area 1	Area 2	Area 3		Area 4
Assessment of client, to decide if CMP is appropriate and guide choice of CMP interventions (where applicable)	Pathways advisers decide to refer client to CMP. Further assessment conducted by CMP practitioners to determine if CMP is appropriate.	Pathways advisers decide to refer client to CMP. Further assessment conducted by CMP practitioners to determine if CMP is appropriate.	Pathways advisers decide to refer client to CMP. A second assessment conducted by sub-contractor 2. A third assessment by practitioner at first session who determines programme content for the individual.	Pathways advisers decide to refer client to CMP. Further assessment conducted by CMP practitioners to determine if CMP is appropriate.	Pathways advisers decide to refer client to CMP and to which particular intervention(s). If client meets individually with a practitioner, the practitioner will conduct a further assessment of client needs.
Specific/generic focus on health condition	Specific: two streams of interventions split between physical and mental health conditions.	Generic: the programme does not offer different interventions based on kind of health condition.	Specific: this sub-contractor only worked with people with mental health conditions.	Generic: the programme does not offer different interventions based on health condition.	Specific and generic: 1-1 sessions targeted at either physical or mental health conditions, but group sessions have a generic focus.
Practitioner flexibility to tailor session content to individuals	Practitioner has flexibility.	Deliver modules with set content; some flexibility where conduct 1-1 sessions.	Practitioner had flexibility to mould session content to client needs.	Deliver modules with set content; some flexibility where conduct 1-1 sessions.	Mix of groups with pre-set content and 1-1 sessions where practitioners have flexibility.

Continued

Table 2.1 Continued

	Area 1	Area 2	Area 3		Area 4
Client choice	No choice of modules; 1-1 sessions only (though plans to introduce group sessions).	Initially, client offered choice of (group) modules, but no choice after the programme was re-modelled; 1-1 sessions only upon request/need or if too few people to run a group.	No choice of modules; 1-1 sessions only. Plans to hold group sessions were abandoned because there were too few clients at any one time to make them viable.	Mix of group and 1-1 sessions, but not determined by client choice. Clients can choose the order in which modules are undertaken.	Client offered choice of group modules and 1-1 sessions.
Duration of programme overall	Number of sessions is flexible, but the maximum is 12 sessions, plus six sessions once in work.	Initially a defined duration of 13 weeks; reduced to four weeks after programme was re-modelled.	Number of sessions is flexible, but the maximum is 12 sessions.	Defined duration of 12 sessions.	Not defined; number of 1-1 sessions is not pre-set and participation in some group sessions can be indefinite (e.g. Pilates class, walking group).
Psychological model adopted	Not Cognitive Behavioural Therapy (CBT); use other therapeutic approaches, e.g. psychodynamic counselling.	CBT approach.	CBT approach.	Not CBT; want to enable and empower people not deliver therapy.	CBT model and motivational interviewing model; Forward-looking therapy and employment focused.

2.3.1 In-house or sub-contracted

The study included two Pathways providers who were delivering CMP in-house, and two providers who had sub-contracted responsibility for CMP. In one of the sub-contracted areas, delivery of CMP had originally been split between two sub-contractors. However, when the contract had been re-negotiated it was decided not to re-contract with one of the providers and the other contractor continued with sole responsibility for CMP. Both sub-contractors took part in this research study. There was limited data regarding reasons for sub-contracting, but one manager explained that they wanted CMP to be delivered by an established healthcare organisation that was equipped to deal with clinical governance matters.

All three of the sub-contractors in this research were recognised providers of healthcare services and had a presence across a number of regions in the UK. One of the sub-contractors had CMP contracts in other Provider-led Pathways districts. Two sub-contractors specialised in treatment and support for mental health conditions, though one of these contractors delivered a generic CMP programme designed to help people irrespective of their health condition. The third contractor had experience in working with a broader range of health problems.

2.3.2 Interventions offered

Table 2.2 sets out the kinds of interventions available across the four districts according to whether they were focused at specific health complaints or more generally, and whether group or individual sessions were used.

Table 2.2 Interventions offered

One-to-one delivery	Group delivery
<p>Specific content</p> <p>Mental health:</p> <ul style="list-style-type: none"> • Psychodynamic counselling • Cognitive Behavioural Therapy • Breathing techniques • Distraction techniques • Improving relationships <p>Physical health:</p> <ul style="list-style-type: none"> • Education, advice and practical strategies for physical problems 	<ul style="list-style-type: none"> • Pain management
<p>Generic content</p> <ul style="list-style-type: none"> • Mentoring sessions interspersed with group work of similar themes (e.g. sleep, stress, depression) 	<p>Modules focused on:</p> <ul style="list-style-type: none"> • Healthy living and working • Stress and relaxation • Communication and assertiveness • Managing anxiety and depression¹ • Anger management • Managing relationships at work • Sleep and routine • Unhelpful thinking • Problem-solving • Readiness to work • Pilates² • Walking group • Motivational strategies

¹ Sessions focused on anxiety and depression were available to people regardless of their health condition (in areas where group workshops were offered), as advice on these topics was expected to be useful even to people with primarily physical conditions.

² Physical exercise, such as Pilates and walking, was considered to be helpful to people with physical conditions and/or mental health problems.

Generally, interventions that focused on specific kinds of health problems were delivered during one-to-one sessions, and generic interventions were delivered via group work. There were two exceptions to this pattern however. First, one sub-contractor delivered generic group workshops on a range of themes, interspersed with one-to-one mentoring sessions where the same themes were discussed and applied to an individual's circumstances. Second, where pain management group workshops were run it was expected that only people with physical conditions causing chronic pain would attend.

Furthermore, two different providers were considering introducing group sessions aimed at specific kinds of health problems and needs. Currently, one of these providers was operating separate streams of help for people with mental health conditions and people with physical health problems, only on a one-to-one basis, and planned for specifically-focused group sessions to slot into each of the two streams. The other provider had recently re-adjusted provision, creating a much shorter generic programme aimed at clients who were closer to employment. This change was introduced because feedback from Pathways advisers and some clients suggested that the course was too long, keeping people out of the job market for months or resulting in people becoming ineligible for CMP support part-way through the programme after losing entitlement to Employment and Support Allowance following a Work Capability Assessment. In designing a shorter course, which was biased towards the needs of people with mental health conditions rather than physical health conditions, the provider no longer included routinely a pain management session. However, they planned to add an extra group session to the programme for people requiring help with chronic pain.

Given the variation in session content and design, approaches to helping people with both physical and mental health conditions were also different. Both sets of conditions were catered for to some extent in programmes where mental health and physical health specialists were available for consultation, or where there were group sessions that included content applicable to both mental and physical needs. However, where all the information and advice was aimed mostly at mental health topics and needs, specific help for physical problems was not catered for (as discussed in the previous paragraph).

2.3.3 Practitioner discretion and client choice

There was variation in the extent to which practitioners had discretion in how they helped clients and to which clients had choice about the interventions they undertook. It is not clear from the data the extent to which programme designers considered practitioner discretion and client choice and built programmes around these concepts. However, it is clear that levels of discretion and choice were affected by the programme designs in general, and the use of one-to-one meetings or group workshops in particular. Thus, the providers who routinely offered CMP participants one-to-one sessions afforded their practitioners flexibility to decide the best course of action for each individual, such that it was unlikely that clients came away with the same experiences of CMP. However, in areas where group

'modules' were used as the primary means of delivering an intervention, the session content was pre-set providing practitioners with little flexibility.

Likewise, clients could choose (with the help of practitioners) to do what seemed most suitable for them where providers offered both individual and group sessions, or a selection of group 'modules'. Equally, choice was restricted in those areas where providers offered only one-to-one appointments with a practitioner, or only a set schedule of group workshops. However, providing both individual and group sessions did not guarantee clients choice. In one area practitioners expected clients to attend a series of individual mentoring sessions following the same themes as a series of group modules and, apart from choosing to leave the programme, clients could only decide the order in which they undertook modules. Client choice receded in one area where the sub-contractor had decided to stop using a menu of modules and had replaced it with a standardised four-week course that did not enable people to opt in or out of certain sessions. In this area, one of the few ways clients could exercise choice was to request a one-off meeting with a practitioner, during which practitioners seemed to possess a degree of discretion in how they helped individuals.

Thus, in order for providers to achieve both a degree of practitioner discretion and client choice they needed to deliver both one-to-one sessions and a selection of group workshops. It should be noted that client choice was moderated or facilitated to some extent by either a CMP practitioner or Pathways adviser. As would be expected in clinical practice, at initial assessments (in most cases, the first contact after referral) practitioners offered clients considered opinions on the kinds of help within CMP that would be most suitable for them. In one area, however, Pathways advisers were involved in helping clients choose interventions and only if the client was referred to a practitioner on an individual basis did a practitioner conduct an assessment about an appropriate plan of action.

2.3.4 Programme duration

Three distinct designs for the length of CMP were found among the providers in this research, perhaps unsurprisingly, these were related to the degree of choice and discretion afforded to clients and practitioners. First, where providers had set programmes and clients were expected to complete all sessions offered, CMP had a defined duration of either four or 12 weeks. Second, the programmes offering one-to-one interventions only, and enabling practitioners to tailor support individually, had a maximum number of sessions, but also flexibility about the number actually undertaken, to suit the client. And third, the provider offering a mix of individual meetings and a choice of group workshops did not seem to have applied any limitations on the duration of people's participation in CMP. In this area, practitioners decided in conjunction with clients the number of individual sessions and clients seemed able to attend as many group workshops as they wished, some of which had a set number of sessions and some appeared to run indefinitely (for example, walking groups).

2.3.5 Staffing

Staff background and roles – managers

In the two areas where CMP was delivered in-house, the role of CMP managers varied according to whether they were clinically trained or not. In one area the two managers interviewed had no experience in healthcare services and explained how their role was primarily operational management, ensuring that the organisation as a whole achieved its targets, which included performance management for CMP staff. Although they were line managers for CMP practitioners, they explained that lead practitioners were responsible for colleagues' clinical training and supervision. In the other district the two managers interviewed had managerial responsibility only for CMP and also had frontline duties as practitioners. One of these managers explained the managerial role as working to ensure compliance with clinical governance. The other manager's responsibilities were more varied and apart from seeing clients the role included managing the operation of CMP and linking in with the 'business' managers in the organisation (i.e. other Pathways managers), and clinically supervising practitioners.

Sub-contractor CMP managers all had backgrounds in healthcare service delivery and were either clinically trained or experienced community mental health workers³. Other than line managing and supervising their practitioners, they all had responsibility for the programme's content and delivery, and spent time delivering interventions to clients as practitioners.

Pathways provider CMP managers in areas where CMP was sub-contracted did not have line management responsibility for practitioners. The manager in one of these areas had clinical experience and stressed her role in ensuring compliance with clinical governance standards and best practice, and ensuring consistency in CMP practice across a number of Provider-led Pathways districts. The Pathways provider CMP managers in the other district did not have clinical experience and held responsibilities beyond CMP, being tasked with the overall successful delivery of Pathways or with monitoring all sub-contracts in the district.

Staff background and roles – practitioners

At the time of the research interviews, each organisation currently delivering CMP had between four and six frontline staff, including managers. The provider who no longer had a sub-contract to deliver CMP had used a team of three practitioners to work with CMP clients. Most practitioners needed to travel between a number of delivery sites within the district.

³ By 'community mental health workers' we mean people who have not undergone specialist clinical training but who are required to have some qualifications in social work or social care provision. These professionals typically work for local authority community mental health services or voluntary organisations delivering support for people with mental health conditions.

In the two in-house areas all the practitioners were clinically trained as psychologists or psychotherapists and physiotherapists or occupational therapists, and used their expertise to perform tasks including:

- conduct initial triage (i.e. determine whether the referral is appropriate) and in-depth assessments, and devise action plans;
- deliver one-to-one interventions (by providing psychological support, or information and advice to help manage physical problems);
- **(in one area only)** facilitate group workshops, giving people information about healthiness and well-being and practical coping strategies;
- hold three or four-way meetings with the client, Pathways adviser and another practitioner (as appropriate);
- review client progress.

These in-house practitioners also described a number of secondary roles, including:

- training Pathways advisers to understand more about CMP, including what makes an appropriate referral and where to signpost clients who are not appropriate for CMP;
- supporting and 'up-skilling' Pathways advisers in their work with clients through information and advice given at case conferences⁴;
- supervising less experienced CMP colleagues;
- conducting outreach by visiting local organisations to promote CMP.

Two of the sub-contractors employed a mix of clinically experienced practitioners and people with no clinical training. One of these providers employed trained counsellors with expertise in cognitive behavioural therapy or neuro-linguistic programming, as well as psychologists, and their main tasks were similar to those listed above, except that interventions were not delivered routinely on a one-to-one basis and they did not hold shared meetings with clients and Pathways advisers. Secondary roles performed by practitioners of this provider were undertaking administrative tasks (such as maintaining databases) when the administrator was away and carrying out research to inform best practice, when time permitted. The other sub-contractor employed clinically trained people (such as nurses) to conduct initial assessments, prepare action plans, conduct end reviews and supervise non-clinically trained staff. The tasks of facilitating group workshops and 'mentoring' (explained as encouraging people to achieve goals set in action plans) through one-to-one contact were the remit of staff without clinical training. These staff members had come to CMP with experience of working in complementary therapy,

⁴ Case conferences are meetings between Pathways provider staff (including Pathways advisers) and CMP practitioners with the primary aims of discussing difficult cases and generating and sharing ideas for meeting client needs effectively.

teaching or community programmes (for example, working with prisoners). More recently, since a job outcome target had been applied to CMP, these mentors had been asked to help clients identify suitable job roles.

The staff at the sub-contractor who was no longer delivering CMP were not clinically trained but had varied experience of working in community health services and one practitioner had previously had a role in the NHS-led CMP in another district. These practitioners met clients individually and used cognitive behavioural therapy and other established techniques to help remove barriers, improve well-being and achieve goals set in their action plan.

CMP managers and practitioners were not asked systematically for their views on the necessity of clinical training or experience of healthcare services to work in CMP. However, some managers spontaneously explained that it was important for them, as staff supervisors and with responsibility to adhere to clinical governance legislation, to have clinical backgrounds. A CMP manager who was not a health professional considered it important that all the practitioners were clinically qualified as most of their work was unsupervised. A similar view was given by a practitioner who felt that all CMP staff should be health professionals with clinical experience to possess the necessary awareness of clinical standards. Furthermore, a number of practitioners thought that their previous training and experiences in healthcare had been useful preparation for their CMP role.

Recruitment and retention

There were signs that recruitment had not been easy, with some managers referring to the jobs on offer as part of a 'niche' labour market. Recruiting desirable, experienced professionals had been helped by using a health recruitment agency in one area, and advertising their use of clinical governance standards was thought to have been useful in demonstrating that a job in CMP would be similar to other clinical practice (i.e. in the NHS). One more recent appointment had been easier to make because the manager involved already knew the practitioner and was aware that they were finishing another job.

Since CMP began, staff teams in some areas had expanded to meet demand, or there were plans to recruit extra practitioners. During this period, all except one CMP provider had lost at least one member of staff. There were hopes among managers that staff would want to stay working for CMP because it provided a different opportunity to learn and to implement their knowledge. However, there were also concerns about staff turnover because of the comparatively low pay (compared to NHS) and the autonomous nature of the job. Working autonomously was said to demand good organisation skills and high levels of confidence and competence and it was suggested that not all staff who had originally been appointed to CMP had possessed these skills and competencies. Few practitioners discussed these concerns, but one view was that the salary paid did not correspond adequately to the professional nature of the job. Although no practitioners linked comparatively low pay to their own job satisfaction and

future plans, there was a view that, in time, it might contribute to high rates of staff turnover. Furthermore, if rates of pay did not improve, CMP may only attract junior level professionals as replacements.

Staff training

The research interviews included discussion on the training provided to and undertaken by practitioners (which included managers who also had frontline roles). Only one of the managers who was not a health professional talked about her own induction and explained how it had included time with CMP practitioners learning about the 'bio-psycho-social model' and advice from another operations manager about how to manage CMP practitioners.

All CMP practitioners in this research had completed an induction of some kind early on in their post. The duration of inductions, and the detail covered, varied with some lasting between one and four days, and others taking one or two weeks. The training content was also different depending on practitioners' level of expertise in dealing with people with health problems. Thus, those who were qualified health professionals or had counselling experience were expected to perform their professional roles without extra training to deliver CMP interventions. Mostly, their induction focused on organisational and operational matters, such as:

- background information about the Pathways provider organisation;
- the aims and structure of Pathways to Work and the place of CMP within it;
- operational processes and paperwork in Pathways as a whole and CMP in particular;
- the expected characteristics of the Pathways client group;
- the content of group workshops they would be delivering.

Inductions focused solely on organisational issues were led by company human resources staff and were received with mixed views. Some staff thought that the induction had been 'pointless' and more suitable for Pathways advisers, but others appreciated being given an overview of the Pathways programme and felt that they had gained new insights into their role.

Sometimes, inductions for qualified health professionals included some elements of professional development, to meet the particular challenges expected in CMP. For example, practitioners talked about training sessions on working as a sole practitioner, working closely in a cross-disciplinary team, facilitating group sessions, observing professional boundaries, and listening skills. These training sessions were designed and facilitated by lead practitioners and (in one area) staff from the provider's training and development department.

Providers employing staff without previous extensive experience of working in the health sector also considered operational issues in their induction (which sometimes included work-shadowing Pathways advisers to learn about their role). However, in addition, they also spent time improving staff skills in delivering one-

to-one and group interventions. Examples of topics covered in these inductions were:

- the theory and practice of Cognitive Behavioural Therapy;
- the kinds of barriers presented by people with health conditions;
- providing support over the telephone;
- building confidence and life skills;
- health and safety.

Training experts or health professionals within provider organisations were drafted in to help CMP managers plan and deliver this training. One sub-contractor was not completely satisfied about the quality of this training as, at the time it took place, some elements of CMP had still to be designed.

The data also suggests that some CMP providers made provision for ongoing or further staff training and development. Mostly this occurred through clinical supervision or staff support and any opportunities undertaken by clinicians to practice externally. One manager explained how staff were routinely offered basic training, such as personal safety or risk assessment training, some of which was available online. In response to the needs of Pathways advisers, managers of one in-house CMP provider organised two days' training about mental health education and awareness to which CMP practitioners were invited. Although practitioners considered this training useful, they also thought that it added little to their existing knowledge.

A number of managers and practitioners were asked about their awareness of Disability Equality Duty (DED) training, which DWP expects providers to cover with staff. None of those who were asked as part of this research recognised DED training as a specific part of their CMP inductions. There were however practitioners who said that their CMP training had explored something similar, such as the Disability Discrimination Act or diversity and equality in general, and practitioners who had come across DED training in previous jobs in the NHS or Jobcentre Plus.

2.4 Summary

This chapter has illustrated the variety of CMP design in the four study areas. It has provided context for discussion of findings relating to experiences of delivering and taking part in CMP (reported in the next four chapters).

As expected with the use of a 'black box' model of implementation, the provision of CMP differed on a number of key structural and operational elements. One prominent way in which CMP provision varied was that it was provided in-house by the Pathways provider in two areas, and was contracted out in two other areas. The findings show that Pathways providers passed on detailed plans for the

design of CMP provision to sub-contractors. No performance indicators relating specifically to CMP were included in Pathways providers' contracts with DWP, but one Pathways provider had recently set its CMP sub-contractor a target to move 15 per cent of CMP clients into paid work. Despite this, there was agreement among many CMP managers and practitioners that job outcome targets for CMP would give the programme an inappropriate focus and might motivate clinicians to act unethically.

Another notable way in which CMP provision differed across the four areas was the kinds of interventions offered to clients. CMP providers offered either interventions aimed at specific kinds of health conditions (such as mental health conditions, or physical health conditions), or generic interventions, or both. It was often the case that one-to-one meetings were used for interventions of a specific nature and that group sessions supported delivery of generic interventions. It was evident that programme design had the potential to affect the levels of practitioner discretion and client choice. Thus practitioners had more freedom to tailor-make support for individuals in one-to-one sessions, but often had set schedules to follow in delivering group sessions. Clients could choose what seemed most suitable for them where both individual and group sessions or a menu of group sessions were offered, but choice was restricted where CMP consisted of only one-to-one meetings or a set programme of group sessions.

Although there were differences in programme design and delivery there were common understandings about the main purposes of CMP. These were described as: helping people gain a better understanding of their health conditions and explore the barriers to improved well-being; helping people manage health conditions to improve quality of life and the likelihood of working again; and empowering people to manage conditions through the use of various coping strategies. Some differences in interpretations of how CMP helped people can be attributed to whether the programme offered therapeutic or non-therapeutic interventions.

Differences across providers in the qualifications and experience of CMP practitioners were linked to whether they were recruited to deliver therapeutic or non-therapeutic interventions. Some practitioners and managers shared the view that it was important that CMP practitioners had clinical training and experience, to be aware of clinical standards when dealing with people with health problems. Training in preparation for their roles as CMP practitioners differed depending on individuals' level of expertise in working with sick or disabled people. At the time of the research study, some CMP managers had experienced problems with staff recruitment and had concerns that the retention of clinically trained staff would be difficult in the long-term if they could not raise salaries to be comparable with NHS pay.

3 Learning about CMP and the referral process

This chapter looks at how clients came to learn about Condition Management Programmes (CMP). It also considers the CMP referrals process from the experience and perspective of clients, Pathways advisers and CMP practitioners. Section 3.1 sets out the ways in which clients learnt about CMP and the ways in which the Pathways advisers introduced CMP to clients. Clients' initial impressions and reactions to CMP are discussed in Section 3.2. Section 3.3 explores client, adviser and CMP staff experiences and perceptions of the referral process. Section 3.4 considers adviser, CMP practitioner and client perceptions of the appropriateness of referrals and Section 3.5 looks at client and CMP practitioners' experiences of the initial assessment. Section 3.6 concludes the chapter with a summary of the main findings.

3.1 Awareness and understanding of CMP

Analysis of data from clients and Pathways advisers highlighted a number of ways in which clients had come to learn about CMP. These included:

- through leaflets from the provider sent through the post;
- from Pathways staff, including the clients' adviser;
- from Jobcentre Plus staff;
- from friends or acquaintances.

Some people had been sent leaflets through the post from the provider. In such cases people could be hearing about the Pathways provider and CMP for the first time, simultaneously. Others said they had heard about CMP from their adviser. Some other people said that they had heard about CMP from someone at the provider but they could not remember, or were not quite sure about, who this had been.

Pathways advisers spoke about a number of different ways of introducing CMP to Pathways clients. Some advisers seemed to have operated with a set procedure of introducing CMP, for example at the first work-focused interview. Other advisers said that they did not have a set time for introducing CMP to clients. This finding mirrors data from clients which showed that the timing at which people had learned about CMP varied. Some people had learned of the programme before having had any contact or work-focused interviews at the Pathways provider; other people reported that they had heard about CMP from their adviser at various different stages of their contact with the provider, ranging from the first to the last work-focused interview. For some people, being told about CMP seemed to have come about when they had asked their adviser for some form of help, for example with their confidence or low self esteem, or after having become tearful or upset during a discussion with their adviser.

Some advisers reported that they usually explained CMP to clients by telling them that it was one of a number of support options available to them. Other advisers suggested ways in which CMP might be able to improve or help clients to manage their particular health conditions. Some advisers talked about making sure they presented CMP to clients in a favourable light and said that they attempted to make it sound as non-threatening as possible. There were also instances of advisers in an area where CMP was provided in-house inviting CMP practitioners over to help explain the programme in more detail to clients. Some also spoke of using the CMP leaflet to talk through the programme with clients. The data showed that advisers had gained their knowledge about CMP in a number of ways. Some used the CMP leaflets and others had conversations with CMP staff to find out more about CMP. Some advisers felt that they were not as knowledgeable about CMP as they would like to be to encourage clients to take part.

Pathways advisers differed regarding which of their clients they **told about** CMP. Some advisers reported that they told all of their clients about CMP while other advisers appeared to have been more selective and only told some. Those who took the latter approach said that they told the following kinds of clients about CMP:

- people considered to have specific barriers which might be helped by CMP;
- people with enduring health problems, such as anxiety and arthritis (who were thought to be likely to benefit from developing coping strategies for their conditions, and then be able to return to work);
- people who had been 'screened in' by a screening tool which was used to determine eligibility specifically for CMP.

There were also differences in which clients were subsequently **referred for** CMP by advisers. For example, some advisers referred only those clients they perceived were engaging with the provider and who were turning up for their work-focused interviews. Other advisers reported being prepared to refer those clients expressing an interest in CMP as long as they were shown to be eligible after answering CMP

screening tool questions. Some advisers referred clients when they were near to gaining paid work. Other advisers spoke of offering CMP to people who had never accessed services such as counselling previously and some looked for specific social or health conditions which might lead them to refer clients for CMP, for example mild to moderate mental ill health; anxiety; isolation; the lack of a social network; bereavement; those with very demanding caring roles or osteoarthritis.

3.1.1 Clients' initial understandings of CMP

Clients' initial understandings of CMP were quite wide ranging and varied within areas. Some people seemed to have an initial understanding which was very closely related to the name of the programme and understood that participation in CMP would help them to manage their health condition(s). Other people had initially understood that CMP was designed to impart techniques that would allow them to understand and deal with their health on a day-to-day basis. Some understood that the programme would help them with their health condition(s) and (therefore) help them to return to work. Others mentioned that they had understood CMP as a range of courses and/or opportunities for physical exercise that would help with health and fitness. Some people had been expecting CMP sessions to partly focus on paid work while others had formed the impression that the sessions would have nothing to do with paid work. A number of people reported that they had not been clear about CMP at the initial stage and had not known what to expect from it, or could not remember what they had understood about CMP at that stage. There were CMP practitioners who said that some clients had come to them with expectations beyond what CMP could deliver, for example, expecting to see their symptoms cured.

There were a range of understandings concerning whether clients were required to attend CMP sessions as a condition of receiving benefit. Some people had understood that their participation in CMP was entirely voluntary but others had perceived that they were compelled, in some cases by their adviser, to take part in CMP or they would lose benefit. While understanding that their participation was voluntary, some other people reported that they felt obliged to take part in CMP because it had been offered or because they wanted to show their adviser that they were willing to help themselves try to get (back) to paid work.

3.2 Clients' initial impressions and responses to the offer of CMP

Clients were asked what their initial impressions had been after receiving information about CMP, to which there were a range of responses. Some people thought that the programme sounded 'brilliant' or 'good' and thought that the help on offer was just what they needed and were therefore pleased about the prospect of accessing CMP. Others thought that CMP sounded like a reasonable idea and that it seemed as if it might help them understand and manage their condition and, in some cases, to make progress towards paid work. Some people

mentioned that they envisaged that they would get to see trained professionals who would understand their health condition(s). Other people reported that they had been impressed about being offered access to a private sector service because they assumed it would be of superior quality. People in an area that offered a choice of individual sessions and a range of group workshops reported that they were also impressed on hearing about the amount of support on offer through CMP. There were some other people who did not think that CMP would be suitable for them – for example those who felt too unwell to think about paid work in the near future – but thought that they would ‘give it a go’ and see what it would be like.

Clients’ reasons for participating in CMP were, as we might expect, not too dissimilar to the themes outlined above. Some people reported that they had been struggling with their health conditions and that they saw CMP as an offer of help, for example with their mental health condition. Some other people spoke in terms of having wanted to ‘get sorted’ or to get a ‘normal’ routine and some confidence (back) into their lives. Others said that they would have done ‘anything’ to improve their health condition(s); to such a level that might get them (back) to a position where they could think about paid work. Some people were keen to take any kind of help at all which was offered to them (from the provider or otherwise), and therefore saw CMP as an opportunity that should not be turned down. Pathways advisers’ perceptions of why clients took up the offer of CMP largely correlate with clients’ reasons. Some advisers said that most clients who were offered CMP were keen to try it, mainly because they had been waiting a long time without treatment of any kind or had been on NHS waiting lists for some time. Some people were perceived by advisers as thinking that CMP had sounded ‘great’ and appeared very keen to access it when they were offered the chance.

Other clients were considered by advisers to have been apprehensive about taking up the offer of CMP because, for example, they lacked confidence in social situations, were scared of what CMP would be about or saw the service as appropriate only for those with severe mental health conditions. Advisers perceived that people who were socially isolated could sometimes feel daunted by the level of social interaction that would be involved, for example in a group setting. Some advisers said that for the latter people, it was important to stress that CMP was voluntary and that when they did so clients were more willing to think about taking it up.

Some clients reported that they had attended CMP because they had been impressed by their adviser’s explanation of CMP and either trusted their opinion or wanted to show willing. Others had gone to CMP primarily because they had felt ‘pressured’ or ‘forced’ to do so by their adviser (or lose their benefit), but also said that they had gone with an open mind about what it might be like.

Pathways advisers’ perceptions about why people might refuse the offer of CMP were varied. One reason given was that clients were already receiving treatment and so did not consider that they would get any additional benefit from CMP.

Other clients were perceived to be wholly focused on searching for work and had told the adviser that they were not interested in attending CMP. Some advisers also thought that clients could sometimes be overwhelmed by the amount of information that was given to them about Pathways. They perceived that telling clients about CMP could add to such feelings and some clients therefore needed time to think about the offer of CMP. Some advisers felt that most clients underestimated the potential for CMP to make a difference to them, but that all those referred subsequently reported that taking part had helped them in some way.

3.3 The CMP referral processes

This section draws on data about the CMP referral process from clients, CMP practitioners and Pathways advisers. Clients were not asked directly about the referral process during their interviews but some people did provide data about it. The three main topics that emerged from the data were:

- the referral processes used by Pathways advisers and CMP practitioners;
- problems making and receiving referrals;
- experiencing delays when accessing CMP.

3.3.1 Referral processes

A common part of the referral process was using a screening tool to help decide whether to refer a client to CMP. The screening tool asked in-depth questions about the client's life and health and determined their eligibility for CMP. Pathways advisers talked of the CMP screening tool screening out people who were severely disabled, or who misused drugs and alcohol, as not suitable for CMP intervention. Some advisers said they applied the screening tool only to clients who they considered were likely to benefit from CMP. Some advisers reported that where they did not feel sure about referring a client for CMP they asked for the opinion of the CMP practitioners. There was some evidence to suggest that the referrals process could be helped where there was physical proximity between advisers and CMP practitioners. In-house CMP practitioners in one area spoke of sometimes being able to engage with clients at the time of their referral for CMP, with the adviser present. Advisers who shared office space with CMP staff (whether in-house or sub-contracted) also spoke of physically handing over and sometimes also e-mailing a referral form to their CMP colleagues. Some advisers talked about using an on-line referral form that they printed and handed to CMP practitioners.

3.3.2 Problems making and receiving referrals

Some problems in referrals were also noted where two sub-contractors were initially involved in the delivery of CMP because of the complexity this introduced into the referrals process. In one area referrals had to go through two or three intermediaries before they reached the CMP practitioner. Staff described a referral process where those in the lead organisation received referrals from advisers and

then carried out a telephone assessment with the client before referring the case back to the adviser. The adviser then contacted one or other of the organisations to refer the client to, depending on their health condition. CMP practitioners in one of these organisations reported that the referral notes they received from advisers varied greatly in the content and depth of information they contained about a referred client. CMP practitioners in another area similarly spoke of getting paper referrals from the adviser which contained very brief details about the client and one practitioner said that they had a brief conversation with advisers to get their opinion of the clients' situation. Practitioners in another area described a process of receiving paper referrals from advisers. Mostly they perceived that they got all of the relevant information at the time of referral but some thought that more information could be provided about the clients' health condition.

3.3.3 Delays when accessing CMP

Time delays in accessing CMP provision emerged from interview data with people in all of the areas. Some clients reported that they had been able to access CMP almost as soon as they had agreed to be referred, within two weeks in one area. Other people reported that they had been waiting for a number of months (one estimate was three months) before their first appointment and that they had been disappointed by this. One client reported that a mistake had been made during the referral process and that there had been a delay of around a month between the initial assessment and the start of CMP modules. One person said that she had received a letter to apologise for the delay, though another explained that she had contacted the Pathways provider to find out what was happening about her referral when she had heard nothing else about CMP.

CMP practitioners and Pathways advisers also said that waiting times for CMP were estimated to be a month or two months each between referral and initial assessment and between assessment and starting CMP sessions. In the area in which two sub-contractors were involved in the delivery of CMP, referrals were reported by CMP practitioners as sometimes going astray and this might not be discovered until a month or so later. Data from CMP managers and practitioners highlight some potential reasons for delays in CMP. Staff shortages and staff turnover, as well as inadequately sized facilities, were thought to contribute to long waiting lists in three out of four areas. In some areas this was because providers did not have enough staff to meet demand, but also one provider considered delays a result of not having enough office space to conduct assessments and group sessions simultaneously. There was a view from CMP practitioners and managers that the long wait had contributed to high drop-out rates.

A number of Pathways advisers said that some clients had lost trust in them because they had been waiting so long for promised support from CMP. Advisers also had concerns about people being held back from making progress towards job readiness and losing motivation while waiting, and this view was shared by some clients in this research who felt that the long gaps between appointments had hindered their progress and left them frustrated. Delays were experienced as

disappointing by clients in this research who had been very keen to start CMP as soon as possible.

3.4 Appropriateness of referrals

This section considers Pathways advisers' and CMP practitioners' notions of an appropriate referral. Adviser notions of what constituted an appropriate referral to CMP differed and, in some cases, changed over time. In one area, where CMP provision had recently been geographically relocated, an adviser spoke of referring fewer people who would have difficulties in travelling a greater distance to CMP. Another adviser noted that referral rates had risen over time and had initially been low because they had not felt encouraged by management to use CMP. One adviser had initially referred only those clients who seemed relatively close to accessing paid work, but over time had come to refer a wider range of clients. Another said that because of the targets for getting people into paid work he only referred to CMP those clients who he considered were the most job ready.

Some advisers thought that they had not received enough training or information about what an appropriate referral to CMP might be and wanted more instruction so that they could present CMP to clients in a more informed way. There were advisers who were aware that some of their referrals to CMP were not always considered appropriate because some clients were sent back to them by CMP practitioners, such as clients who had been recently bereaved, clients who misused drugs or clients who were agoraphobic. One view was that advisers were sometimes aware at the time of referral that the client might not be considered appropriate for CMP by practitioners (for example people who misused alcohol) but that they were referred anyway in the hope that they could be helped.

Some CMP practitioners thought that there were advisers who lacked an understanding about which of their clients might be appropriate to refer to CMP. Some of these practitioners also thought that increased adviser training in both CMP and in some prevalent health conditions would help advisers to make more appropriate referrals. Other practitioners noted that while advisers were told about CMP, problems of inappropriate referrals could be caused by the turnover of adviser staff with new staff arriving on a regular basis needing time to learn what would constitute an appropriate referral. In one area, where there had been two sub-contractors, there had been concerns that one organisation was not fully aware of what the other offered and this had implications for the appropriateness of referrals.

Some CMP practitioners said that the number of appropriate referrals had increased over time as advisers learned about CMP from liaising with CMP practitioners and from having had clients referred back to them as not appropriate. Notions of what made an appropriate referral varied among CMP staff. Some said that they were looking for clients with less severe needs who, for example, might be close to the labour market but lacking in confidence. One practitioner was aware of having

accepted referrals for CMP that colleagues would have found inappropriate and thought this was because of her specific professional background and experience of dealing with people with more severe needs. Indeed, some other practitioners said that they had received referrals for people with more severe needs and that these were not appropriate for CMP. If considered an inappropriate referral, some practitioners reported that they would refer clients to mainstream clinical services which might be able to help them. Clients with medical conditions which meant they were very ill, or who were undergoing exploratory treatment, or waiting for a diagnosis, were also thought by some practitioners as inappropriately referred to CMP.

3.5 Experiences of the initial CMP assessment

This section begins by considering CMP practitioners' understandings of how they used their initial assessment with clients. Some practitioners reported that they were using an assessment tool in the first session to assess a client's suitability for CMP. The tools used by different practitioners ranged from being perceived as comprehensive in their consideration of people's barriers and life situations to being seen as 'ridiculous' in the types of questions they were prompted to ask clients. Some practitioners reported that, because of the unsuitability of their current screening tools, they were awaiting newly designed ones.

Practitioners also reported that they used the initial session with clients not just to assess whether people were suitable or not for participation in CMP, but also to tell them more about the programme. At this stage, one person in the research study had refused the offer of CMP after having learnt more about CMP. This person did not feel able at that time to take part in group counselling sessions and was not offered any individual counselling. Some practitioners used this session to complete questionnaires with clients which would then be completed again in their final CMP session. The differences between the client's responses in the two questionnaires would be used to assess their progress.

Some practitioners reported that this initial session was partly used to decide with the client the nature of the CMP sessions that they would attend (i.e. group workshops or one-to-one sessions). In some part this relates to whether the structure of CMP in areas allowed for any such choices. Some practitioners reported that they collaborated with colleagues (for example, a physiotherapist with a counsellor) to work out the best provision and the most appropriate coordination of different types of provision so that the client received maximum benefit from CMP.

Not all CMP providers offered clients choice about the sessions they took part in. Where there was choice offered, one practitioner thought it was best not to overwhelm people with a lot of information at an early stage in CMP. The practitioner would therefore direct clients to meetings that were thought to be of benefit to the individual until clients were familiar enough with CMP to know what was available and to make a choice.

3.6 Summary

This chapter has considered the CMP referral process from the perspective of clients, Pathways advisers and CMP practitioners. It has shown that clients in this research heard about CMP at various different stages in their contact with the provider. Adviser data highlighted that there were also differences in which clients were **told about** CMP and which clients were **referred** to CMP.

Clients reported having participated in CMP for a number of reasons. Some said that they had not been offered any help or support from any other sources and so welcomed the opportunity to attend CMP sessions. Others wanted to learn how they might manage their health problems better. Some of these people also wanted to use CMP to improve their health enough to find paid work. Some other clients had perceived that they were compelled to attend CMP or they would lose their benefits. Pathways advisers' perceptions of why clients had accessed CMP included the lack of health care from other sources and sometimes very long waiting lists for NHS services. Confidence building was also seen as a reason for Pathways clients attending CMP. Some advisers noted that some people did not understand that CMP was voluntary and perceived that when they made the voluntary nature of the programme clear to clients they might be more likely to participate.

Experiences of the referral process suggest that for some clients the process worked well, ran smoothly and that they were able to access provision relatively quickly after having been referred. Other clients however had experienced a delay of a number of months between being referred and their first CMP session. This had been disappointing for them where they were very eager and keen to start the programme. Advisers in different areas reported a range of different processes for referring and these varied in the extent to which they could refer straight onto CMP practitioners, with some processes having two or three intermediate contacts before reaching the CMP practitioner. While CMP practitioners mentioned that there was sometimes only the barest information about a client who had been referred to them by the adviser, in-house CMP practitioners talked about being more involved in the referral process with advisers. The latter point suggests the potential benefits arising from physical proximity of advisers and CMP practitioners.

There were no agreed notions of what constituted an appropriate referral either within the different groups of clients, advisers and CMP practitioners or between them. Advisers felt that appropriate referrals encompassed criteria about the severity of a client's health condition(s), or their willingness to work with the Pathways adviser, or their distance from the labour market. Contextual factors, like geographical location, whether the use of CMP was encouraged by management and adviser constraints of targets for getting people into work were seen to influence whether and why clients might be referred by advisers to CMP. The data suggested that between advisers and CMP practitioners, at least, there might be more scope for agreement and understanding about what constitutes an appropriate referral where there is adviser and practitioner learning and sharing.

Chapter 7 will return to the following themes drawn from the findings in this chapter:

- adviser differences in what constitutes an ‘appropriate referral’ and whether this is a potential source of inequity for clients;
- whether delays in accessing CMP might affect clients’ engagement with CMP and Pathways provision in the future;
- adviser training on the nature and purposes of CMP to improve appropriate referrals;
- that differences in clients’ understandings about the nature and purpose of CMP might inform their expectations of it;
- the extent to which in-house CMP provision or physical proximity might foster better communication and smoother referral processes between advisers and CMP practitioners.

4 Experiences of CMP delivery

This chapter explores multiple perspectives of experiencing CMP delivery. In Section 4.1 CMP practitioners' experiences of delivering interventions and clients' experiences of receiving them are reported, looking in particular at the content and format of CMP sessions and what was helpful or not so helpful about these sessions. Section 4.2 draws attention to the extent to which CMP sessions focused on work. Client expectations of further CMP contact are discussed in Section 4.3, before findings from CMP practitioners, managers and clients about non-attendance are presented in Section 4.4. Experiences of delivering or receiving in-work support are reported in Section 4.5 and the final section in this chapter exploring findings (Section 4.6) looks at practitioners' experiences of support and supervision. The chapter findings are summarised in Section 4.7.

4.1 Experiences of delivering and receiving interventions

This section presents findings about CMP managers' and practitioners' experiences of delivering interventions and clients' experiences of receiving them. This section draws on the data from people who had some experience of CMP beyond the initial assessment. It is also important to note at the outset that some people could only give limited or partial accounts because they had attended very few CMP sessions or were still participating in CMP at the time of the research interviews.

4.1.1 Experiences of the content and format of CMP sessions

As highlighted in Chapter 2, CMP providers used individual sessions or group workshops, or a combination of both, to deliver themed interventions. Among the research participants, there were CMP clients who had had the following experiences:

- individual meetings only (with either a mental health practitioner or physical health practitioner, or meetings with both);
- group workshops only;

- both individual and group sessions (with variation regarding which came first);
- telephone contact with practitioners between individual or group appointments.

Chapter 2 explains how some CMP providers did not offer clients a choice of individual sessions or group workshops as one format was used for all programme delivery. However, in an area where all CMP interventions were delivered in groups, some clients explained how they had come to have one-to-one contact with practitioners outside of the initial and final assessments. This was scheduled where the client had been unable to attend a group session and had been offered an individual session to catch up, but also happened in unplanned situations where other group members did not attend leaving one attendee, or where the client had become upset during a work-focused interview and a CMP practitioner was on hand to offer help immediately.

Individual meetings

Staff explained that the number of individual sessions provided for a client depended on their individual needs and level of motivation. For sessions focused on mental health problems, this was typically four to six sessions per client, though there was greater diversity in what was considered the norm for physical help with one, or three to four, or six to eight sessions thought to be usual. Mostly, individual sessions were either held weekly or every two to four weeks. However, the frequency of contact could be determined by client needs and activities with gaps between appointments extended when wanting to give people time to realise their participation was drawing to an end, and intervals shortened where practitioners were keen to check on how the client was getting on with applying suggested condition management techniques. Session durations were typically 50 to 60 minutes, with shorter appointments for follow-up meetings in some areas and longer sessions where practitioners felt this was necessary.

For the most part, client accounts matched staff data about the number, frequency and duration of individual sessions. However, some people commented that intervals between meetings had become longer over time, or longer than expected, because they said that practitioners were much in demand and could not accommodate more frequent contact.

Staff and clients described similar stories of what happened during individual meetings, with the following main elements:

- an introduction;
- an opportunity for clients to provide background information about themselves, including medical history and current problems;
- verbal and written information and advice from practitioners to improve general health, manage health conditions or to resolve or minimise problems;
- goal-setting and writing an action plan;
- a review of previous goals, activities and progress.

Introductions at the first session usually explained what would happen during CMP sessions and that attendance was voluntary. Following this, clients and practitioners described an opportunity for the client to talk about 'whatever they wanted', including current and past problems, fears, barriers to work and future aspirations. This meant that it was possible for clients to set the agenda for what was discussed, and ignore agreed plans to discuss certain topics where they felt that another matter was more pressing.

Practitioners' responses in the form of information and advice varied according to what they had learned about the client, but commonly identified practical steps to improve conditions or challenge fears, encouraged positive thinking, highlighted the importance of improving general health by diet and exercise, and stressed the benefits of being in a routine. To meet individual needs practitioners had, on occasions, advised clients to approach their GP to request more medical help, or other organisations for specialist help (for example, for help with an alcohol problem). Where group workshops were also offered by the CMP provider, practitioners sometimes used time with individuals to suggest appropriate group interventions. Various tools or techniques were utilised by practitioners to identify problems or to reduce their impact, including therapeutic approaches (such as person-centred therapy or cognitive behavioural therapy), pulse oximeters, heart rate monitors, equipment for physical exercise, breathing techniques, meditation and relaxation. Written information about conditions and management techniques, and diary-writing, were other methods used to inform clients and empower them to improve their health, and to deepen practitioners' understanding of clients' problems and lifestyles. In one area, practitioners were able to supply clients with free passes to swimming and gym facilities, to encourage improved physical, and mental, well-being.

At the end of each session, clients and practitioners would agree an action plan that set out goals to attempt to achieve before the next session. Subsequent appointments were used to follow-up progress, discuss continued problems and suggest additional management techniques and goals.

In some areas, practitioners used recognised health assessments (for example the Hospital Anxiety and Depression Scale) to monitor and record progress. Other ways of observing progress were to ask clients to complete an end of session summary sheet, to make notes during and after appointments, and to make and review action plans. Practitioners in one area were unhappy about being asked to take notes during meetings because they felt it did not accord with their professional training.

Group workshops

Group workshops were offered in three of the four study areas at the time of the research interviews. In two areas, and at the time of the research interviews, all CMP clients were expected to attend all available sessions in providers' rolling programme of workshops. Previously in one of these areas, and in the third area,

clients were able to choose from a menu of workshops, which meant providers ran individual 'modules' according to demand and clients could be attending more than one workshop at the same time. The third area also delivered drop-in group sessions which ran indefinitely, for example, a walking group and Pilates class.

According to CMP practitioner, manager and client data, typically group workshops were run on a weekly basis and lasted for a number of sessions, though participation could involve attending several sessions per week or completing the entire workshop in one day. The duration of each session tended to be between two and four hours. The number of group members often started out at between eight and 12 people, which was considered ideal by CMP practitioners, but it was common for people to drop out (see Section 4.4 for findings regarding non-attendance). The data suggests that all the available group workshops were considered suitable for all clients, irrespective of their health condition.

Group workshops were organised along different themes (see Table 2.2) but most contained the following elements:

- an introduction;
- an opportunity for group members to explore the cause and manifestations of the problem(s) at the core of the individual workshop theme (for example, stress, anxiety, anger, negative thinking) either through discussing their own experiences or through practitioner explanations;
- clients learning about ways to manage or reduce these problems, sometimes using specific techniques such as breathing exercises or distraction techniques;
- written information to be read at home; and encouragement to complete worksheets (either at home or in CMP sessions) charting individual thinking patterns or feelings or any progress in achieving agreed goals between workshop sessions;
- feedback to the group about 'homework' tasks.

The exception to this was a number of workshops where people learned about resources or strategies for living healthier lives and raising general well-being, but which were less concerned with exploring individuals' experiences of problems. These were either workshops about healthy living (stressing the importance of and giving advice about diet, exercise and social interaction for mental, physical and emotional health) or involved some kind of physical exercise, such as walking or Pilates.

Staff in some areas used one-to-one CMP sessions that ran alongside involvement with group work to keep track of client progress and outstanding needs. In the area where individual sessions were not offered, practitioners held an exit meeting with each participant to conduct a health assessment again (and record any differences since starting the programme) and talk generally about the client's progress and outcomes achieved.

4.1.2 Views about delivery and content of CMP sessions

To understand how and in what ways CMP can be effective, Pathways managers and advisers, CMP managers and practitioners, and clients were asked for their views on what worked well, or was helpful in the delivery and content of CMP, and what did not work so well or was unhelpful. Many factors that were thought to be helpful applied to both individual and group sessions, so the distinction between these two delivery formats is made only where it applies to one of them.

Working well or helpful

When asked what they thought encouraged people to keep attending CMP and engage with session material, CMP practitioners and managers highlighted the importance of building rapport with clients by being open and honest and by listening to clients. There were a number of clients in this research who identified their relationship with CMP practitioners, or practitioners' individual qualities as helpful aspects of their CMP experience. In particular, seeing the same practitioner(s) over a number of sessions, and in both group and one-to-one sessions, was important for continuing engagement with CMP. Also considered important by CMP practitioners and managers was ensuring clients were informed at the outset about what taking part would entail. This could include managing expectations about what outcomes could be achieved through CMP, emphasising that participation was voluntary and informing people about help to access CMP sessions, such as reimbursing travel expenses and providing taxis.

The following were consistently mentioned by CMP staff and clients as working well or being helpful during CMP sessions:

- understanding and non-judgmental practitioners;
- taking an holistic approach;
- providing people with effective condition management techniques;
- focusing on individual problems and needs, and developing individual coping strategies;
- opportunities to meet with other people in similar situations.

Staff and clients emphasised that people needed to feel comfortable with CMP practitioners to talk openly about their problems and to get to the roots of their barriers to work. Perceptions of staff professionalism were influential here, such that those who praised the practitioners they met often attributed the helpfulness of sessions to practitioners' levels of expertise and knowledge of health conditions. One Pathways manager thought that people were more likely to take on board what they were told in CMP sessions because practitioners in their CMP programme were health professionals. However, it seems that practitioners did not have to possess clinical expertise to be recognised by clients as providing expert support. Practitioners who explained their own experience of certain health problems and were perceived as 'knowing what they were talking about', or who

were apparently skilled in drawing out client feelings and being empathetic were also thought to be effective by clients.

Some CMP practitioners felt that holistic thinking that focused not only on improving people's main health symptoms but promoting a healthy lifestyle and a high standard of general well-being was important in service delivery. Similar arguments were made by clients who had found it helpful that CMP had offered help to improve mental, physical, emotional and social problems. Some of these people had attended CMP not realising how their main health problem had affected other areas of their life (for example not fully understanding that a physical problem had had an impact on mental health) and that focusing on these areas would also help to improve their quality of life.

A focus on providing people with coping mechanisms was generally thought to work well by CMP staff and clients. Staff spoke of how giving people tools and resources to manage their problems and symptoms also gave people an element of control over their lives. Mostly, CMP participants said the strategies they had learned had been effective to some extent, for example there were people who said they could now control panic attacks, who felt more relaxed, who had a more positive outlook in life, or who generally felt better after undertaking physical exercise (the impact of taking part in CMP is discussed in more depth in Chapter 6).

The value of individual attention from practitioners, to focus on specific concerns and tailor-made tools for managing conditions, was evident in the staff and client data. Many people said that they simply welcomed having time to talk to someone. It was important for practitioners to respond flexibly to client needs, and there were examples of practitioners providing support outside their usual practice, such as leaving the office to help a client use public transport, sending the client further information via email, or meeting a client without an appointment when they became upset during a work-focused interview. Clients who did not attend any individual sessions did not have the same in-depth individual support, but nonetheless felt it was helpful when groups were small in number and some individual issues could be discussed. Making provision for one-to-one support was thought to be essential by some practitioners and clients, some of whom had only been offered group workshops. They argued that individual sessions were necessary for people who were anxious and lacked confidence (at least initially) about joining a group of strangers, because they afforded private space and more time for people to open up about sensitive matters, and because practitioners could ensure that information and advice was relevant.

However, grouping participants together was also thought to work well, both from the perspective of CMP practitioners in areas where group workshops were delivered, and most clients who took part in group sessions. The advantages of group work were feeling a sense of solidarity in being with other people in similar situations, being exposed to different perspectives on living with certain health conditions, being motivated to make steps towards work by seeing other people make progress, and having an opportunity to socialise (which was felt to

be particularly important for people who had become socially isolated or lacked confidence in interacting with people). A common finding among clients who completed a series of group sessions, was that their initial fear or anxiety about meeting with strangers was overcome when they became familiar with the other group members and with the structure of group work.

Positive comments about CMP premises and locations included finding that the location was convenient for public transport, that the premises were easily accessible (for example, where everything was on the ground floor), and that the environment inside was generally pleasant with facilities such as refreshments.

Other aspects of delivery and session content that were thought to be helpful by clients were:

- having written information about conditions and coping strategies, or 'homework' exercises, which could be taken home and acted as a reminder of what had been learnt during CMP sessions
- learning something new in relation to health conditions and their effects, or living healthily
- explaining health conditions in 'layman's terms' and the use of plain English in literature.

In addition, further elements of CMP sessions that were considered helpful by practitioners were:

- seeing people over a period of time and having opportunities to reinforce positive steps;
- using theory about health conditions to explain and legitimise the way people feel;
- using interactive methods for conducting group work.

Not working so well or unhelpful

Regarding unhelpful experiences of CMP sessions, the following were cited by CMP clients (and practitioners to some extent):

- feeling uncertain about the validity and organisation of the programme and about practitioner expertise;
- not meeting client needs;
- negative interactions with staff or other clients;
- problems accessing CMP locations and using inappropriate facilities.

There were clients interviewed for this research who questioned the validity of the programme either by wondering what kind of theoretical framework or medical standards had informed programme content, or by querying the expertise held by practitioners. In cases where people had thought practitioners were inexperienced,

one response was to doubt the advice they had given and another was to ask practitioners to give details regarding their training for the job. One feeling was that the whole programme seemed disorganised, and this had been manifested in confusing written material and practitioners not knowing which room they could use to take sessions.

There were a number of ways in which clients and staff described CMP as leaving some client needs unmet. Firstly, the support offered in CMP was not always enough to overcome client barriers. Even in areas where one-to-one support with specialists was offered, there was a feeling among some practitioners that CMP could not provide support that was intensive enough to help individuals with deep-rooted problems. These people were thought to need help such as long-term counselling, treatment for addictions, or help from a personal trainer. This was noted by clients in this research who said that individual or group meetings were not long enough to tackle their problems and for practitioners to understand the complexities of their lives. The CMP manager of provision delivered only in groups felt that some people needed interpersonal support through person-centred therapy rather than the CBT-oriented educational programme they currently ran. This view was echoed by a number of clients using CMP in this area who wanted time alone with practitioners to discuss their individual problems and needs.

Secondly, some people whose health problems were primarily physical felt that CMP was biased towards support for mental health problems and that their needs, such as managing pain, were overlooked. These people attended CMP programmes in areas that only offered generic support and which did not employ practitioners with specialist knowledge of physical conditions.

Thirdly, there were a number of people who felt that the material covered in one or all generic group workshops (and generic individual sessions in one area) was 'pitched too low' and was undemanding, was already familiar, or was irrelevant to their circumstances. In particular, they already knew how to manage stress or how to ensure a healthy diet and exercise regime, or felt frustrated at the simplicity and slow pace of the information-giving. Some who felt the content was 'pitched too low' found that the whole CMP programme had not been worthwhile, but there were others who had this opinion about single sessions only and were positive about CMP overall.

Fourthly, the way material was presented could sometimes obscure the potential to meet client need. Examples here were that people with dyslexia, or who struggled with concentration due to mental health problems, or whose first language was not English, found it hard to complete written worksheets that formed part of the session or 'homework'. Another comment was that practitioners should consider using more stories or images, rather than just written words, as this might help people to absorb information and understand ideas.

Another set of critical comments about client CMP experiences were formed around negative interactions with staff or other clients. In one-to-one meetings, some negative experiences were related to feeling that the CMP practitioner did not understand personal circumstances or did not listen and seemed to think that the client was more ready for work than they did. Some clients also found it unhelpful when the practitioner spent time talking about their own experiences or when sessions focused on distressing parts of their past. Some of those who experienced the latter said that they had felt more depressed after CMP sessions than beforehand. In group workshops, attending a group with a dominant person who was generally negative about the course content was found to be discouraging. It was also difficult to relate to other group members where they seemed to be in very different circumstances (for example where most people had mental health conditions but one person had only physical problems). One person who attended Pilates workshops organised by CMP at the local gym found gym reception staff very unpleasant and unhelpful and that this experience was 'discouraging'.

Finally, problems accessing CMP locations and finding facilities inappropriate were also mentioned by some clients and CMP practitioners and managers. As well as facilities not having enough rooms, a common complaint in two areas was that the rooms used were too small for the number of people taking part in group sessions. As a result, some people described finding group sessions very intense and intimidating, although as people dropped out and those remaining grew familiar with the setting they found that being in close proximity encouraged openness with each other. Providers covering a large and mostly rural area found that travelling distances to CMP locations had limited the number of referrals received, and clients who had taken part in this area talked about the effort and financial cost involved in travelling to CMP.⁵ Other negative impressions of the location and premises centred on rooms lacking privacy (where people could see into the room or where it was possible to be overheard); offices being affected by noise from other rooms or from outside; and being in a location that was hard to find, was not well served by public transport, or which did not offer adequate parking.

4.2 The extent to which CMP sessions focused on work

Analysis of CMP practitioner, manager and client data showed that there were three main perceptions of the focus on work within CMP:

- CMP is driven by a focus on work;
- CMP is a work-oriented programme but other goals and outcomes are important;
- CMP is client-led and work is discussed if considered beneficial to the client.

⁵ In this area CMP providers reimbursed travel expenses, but not all clients who took part in the study from this area were aware about the option to reclaim expenses at the time they could have done so.

4.2.1 CMP is driven by a focus on work

Managers from two CMP sub-contractors, and some practitioners from one of these providers, described how work was the central, driving focus of CMP and that this focus was made explicit to clients. Their accounts suggested that work was mentioned at all stages of the programme, from the initial phone call and assessments (explaining that CMP aims to help people manage their health in order to return to work), through sessions using work scenarios as discussion starters or role play exercises, to final sessions focusing on readiness for work and identifying potentially suitable jobs. One CMP manager explained that the recent re-modelling of the CMP provision had been influenced by calls from Pathways advisers to focus more on work. For example, the programme was aimed at people close to job readiness, it was shorter in duration (four weeks long) to encourage people to consider work as part of their near future, and the routine and hard work of day-long CMP sessions was thought to be reminiscent of being at work. This manager felt professionally comfortable with the focus on work, but wondered if clinicians with experience of focusing exclusively on health matters would find this approach difficult to implement.

A small number of clients who took part in CMP in one of these areas also perceived that the programme was heavily focused on work. They felt that every session had been focused on preparing for work, or that work seemed at the centre of everything discussed. There was evidence to suggest that work seemed such a prominent theme because they wanted it to be or because it was personally relevant: one of these people was very keen to return to paid employment and welcomed any help to do so; and another person felt that the topic of work had been noticeable because work issues were at the centre of her mental health problem.

4.2.2 CMP is a work-oriented programme but other goals and outcomes are important

CMP staff perceptions of the focus on work and client responses

Many CMP managers and practitioners from three of the study districts perceived CMP as a work-oriented programme, but felt that other aims and outcomes were important to bear in mind when working with individuals. They recognised that CMP formed part of Pathways to Work (which was aimed ultimately at helping people off benefits and into paid work) and that, therefore, CMP shared the ultimate aim of helping people take steps towards and into work. Indeed, they described how sessions broached the topic of work by, for example, asking people about their barriers to work and their aspirations, by discussing how health conditions might be managed in the workplace, and (for people who sought it) providing help to apply for jobs. However, they were also cautious about treating work as the only aim or outcome that mattered, for a number of reasons. First, there were concerns that if it appeared that work was the 'only agenda' behind CMP, people who were 'scared' about working would not want to continue

engaging with the programme. Second, some practitioners had found it hard to discuss work with people who had not been employed for many years and for whom different focuses seemed more relevant or appropriate. Most of these practitioners felt it was helpful to highlight other, perhaps intermediate, aims, especially during early contact with CMP participants. For example, it was useful to aim first for improvements in general health or management of health conditions. These aims were then linked with having made progress towards work at a later stage. This viewpoint on the extent CMP focused on work was helpfully summed up by one practitioner who said work was 'the last link in the chain' in progress made by individuals; and by another who thought that the inclusion of work in course content was 'surreptitious'. Practitioners who held this view were generally supportive of the focus on work, believing that it was important to consider work matters alongside health issues and to promote the benefits for individuals' lives of undertaking work of some kind.

It was surprising that some practitioners who held this view about the work focus had a manager who perceived a stronger focus on work. One explanation might be that managers' expectations about the importance of a work focus were not clearly communicated to practitioners, thus leaving room for subtly different perceptions and descriptions of the focus on work. It could also be that practitioners were able to exercise discretion in determining the strength of focus given to work in conducting their jobs.

When asked in the research interview how clients responded to course material about work, these practitioners explained that responses varied according to how motivated or ready people were regarding work. In the main, people reacted well to discussing work because they wanted to have a job (at some point) and had chosen to take part in CMP because they needed help to make progress. One view was that CMP was a non-threatening environment because practitioners were not asking people to demonstrate their readiness for work, for example by looking for jobs. However, some people were said to have been initially cautious and wary about being pushed into work, and this had informed or confirmed practitioners' decisions to have more detailed discussions about work in later appointments. It was also explained by practitioners that people who did not respond positively to work-oriented discussions were often people who had not understood the purpose of CMP before being referred and had expected to receive medical treatment. Furthermore, these clients' were often disappointed when the aim of CMP was clarified during CMP sessions and their expectations were not met, and some did not return for further sessions.

Client perceptions of the focus on work and their responses

The majority of clients in this research who came into contact with these practitioners shared the view that there was underlying focus on work but not to the exclusion of other personal aims. They assumed that helping people to return to work was an aim, or the main aim, of CMP because it was part of Pathways. However, they also described how work was not always the main focus

of each session, though often what was discussed (such as building confidence or managing anxiety and depression) could have a positive 'knock on effect' for work prospects. Although there were discussions about work scenarios and aims, time was also spent thinking about non-work situations and goals. People gave examples of how work was tied in to discussions about problems (for example, how people with mental health problems found it hard to sustain employment), or was linked to discussions about practical steps to improve confidence or assertiveness, or to reduce stress (for example, handling stress at work or job interview techniques). There were also people who said that work was mentioned when talking about current situations and goals (for example, giving details of work history or being asked how they felt about work now). Some of these people had noticed that work became more of a focus over time, remembering that in the initial assessment and early sessions work was not discussed at all, but that sessions nearer the end had tackled subjects such as building relationships with work colleagues. One person explained that the aim to help people prepare for work did not 'get in the way of being there to help yourself' in other ways.

People who felt that preparing for work had been an underlying focus tended to find this focus appropriate, or were ambivalent about it. They were often happy with the way work was discussed sensitively and, in individual sessions, was linked to personal circumstances and future plans. One client said that if work had been mentioned right from the start it would have seemed as though the aim was to return to work as soon as possible. However, talking about work at a later stage was considered to be acceptable. Some of those who indicated that they had had negative views about the focus on work explained that these initial views (for example, feeling that the practitioner did not listen and understand that they could not work; or feeling under pressure to return to work) had been mitigated by subsequent experiences, such as group sessions where work topics were discussed but there seemed no pressure to work, and realising that CMP sessions were offering help to make progress towards work. In contrast, clients could have lasting negative impressions of the place of work in CMP where it was felt that CMP did not offer any helpful suggestions beyond what they were doing already to get back to work.

A number of people in one area (where practitioners took the view that work was one focus of CMP but not the only focus) did not perceive that there was a focus on work. Most of these people were either part way through the programme at the time of the research interview, or had ended their participation before reaching the end of all available sessions. This seems to support evidence about work gradually becoming more prominent in CMP sessions over time and that these people had not completed enough sessions to perceive the role of work in CMP. A client who had finished all CMP sessions thought that the main focus had been on well-being and that work had only been discussed because she had raised it. Again, it is possible that work was not brought up initially by the practitioner who was then subsequently led by the client's desire to talk about work. Most people who did not identify a focus on work felt this was appropriate or did not

seem to mind either way. However, one client who had volunteered to take part in Pathways because he wanted to return to paid employment felt disappointed that CMP sessions appeared to contain 'nothing about work'.

4.2.3 CMP is client-led and work is discussed if considered beneficial

CMP staff perceptions of the focus on work and client responses

The third approach to including work in CMP sessions was to be led by individual clients and their circumstances, discussing work if the client mentioned it first or if the practitioner felt it would be beneficial to the client. This approach was adopted by practitioners of one of the in-house CMP providers, who were all clinicians and who offered only individual appointments to clients at the time of the research interviews. One view was that work was a minimal part of their role as CMP practitioners because meeting clients' immediate needs regarding managing health conditions or problematic circumstances was more important. When work was discussed, it was emphasised that CMP was primarily focused on helping people manage their health conditions, which in time might help people to return to work. Practitioners here explained that the time they brought work into discussions with clients depended on what seemed right for the individual and that work might not be mentioned at all. Usually, however, clients themselves would have initiated a discussion about work by the later appointments. Sometimes this was because clients felt their Pathways adviser was pushing them too hard about looking for work and one practitioner recalled asking advisers to 'lay off' clients for the time. One practitioner felt it was appropriate to ask if the client felt ready for work or needed more help, during the last few appointments. Practitioners in this area had worked with clients who wanted to work and they had talked together about suitable jobs and the adjustments and adaptations available for the workplace. Some practitioners were also aware of people who, in their opinion, were moving into work too fast and who they had advised to make slower progress (for example, a client who was to be interviewed for a job but was still having panic attacks). These practitioners believed that people had been able to make more progress in the long run because they progressed at a slower pace.

Despite describing a more cautious approach to tackling work-oriented discussions, one practitioner who talked about client responses thought that half of CMP clients reacted badly when work was mentioned and this had an impact on their continuing engagement in CMP. This practitioner also noted that it was hard to change people's perspective about work in six to eight weeks of appointments if they have been out of work for many years. Another view was that only some clients were sceptical and that efforts were made to assure them that they were not being forced into a job.

Client perceptions of the focus on work and their responses

In the majority of cases, clients of this provider described how work was not a major point of discussion all the way through CMP, but that it was in the

'background'. Some people felt that work was not always discussed upfront because the practitioner was aware that they wanted to work (either because they were a voluntary participant on Pathways or because they knew the practitioner had spoken to their Pathways adviser). Instead sessions seemed mostly to be centred on 'personal hurts' and if work was mentioned this occurred in a later appointment. One client had raised the topic of work in the first CMP session after feeling under pressure from a Pathways adviser to find a job, but the CMP practitioner explained that CMP was not trying to get people into jobs. When work was discussed it formed part of discussions about strategies to feel better, for example, when the practitioner explained that work might be good for mental well-being because it encouraged routine and provided a purpose and distraction. Work was also discussed during sessions when client progress was assessed, for example being asked periodically what kind of work they were interested in and, in the final session, whether they felt ready to consider applying for a job. These discussions felt appropriate for the clients involved, largely because they felt they were making progress, or because they wanted to work (at some point), or because they were ready for work at the time that work was discussed.

A contrasting view was held by some people who thought that helping people return to work had been the main aim of Pathways and therefore of CMP too. One person felt that it had been necessary to make it clear to the practitioner that she was not as ready for work as the practitioner seemed to think. Another client felt work was discussed too much in CMP and this had not been helpful because there were other issues (regarding health and well-being) that seemed more pressing and needed more attention.

4.3 Client expectations of further contact

Many clients in this research were not expecting further contact with CMP. Most of these people had finished all the sessions that had been suggested as appropriate for them and thought the only contact they might have with practitioners was if they took them up on their offers of help on a one-off basis. Those who had not finished the programme but who did not expect further contact had left the programme early because of ill health or bereavement, or because they did not want to continue participating, or because the practitioner they were working with left and the client did not want to continue with another practitioner or was not offered further support.

The remaining clients in this research were either expecting or hoping to attend more CMP sessions, or were considering doing more. This sub-group can be split into those who had future appointments booked, those who did not necessarily have appointments but who expected or hoped to continue participating indefinitely in drop-in group workshops, and those who had no firm plans but who were considering doing more or hoped that this would be possible. Most people who had appointments looked forward positively to the next session, expecting that further involvement with CMP would help them make progress in some way, such

as building confidence and learning effective coping strategies. There were some people who did not know what the next individual or group session would be focused on, but this was not perceived as a concern or hindrance. Those looking ahead to their first group session felt it would be helpful to meet with other people to feel less alone and to learn other people's ways of coping. Knowing that the practitioner who had conducted one-to-one meetings would be facilitating the group workshop was an encouragement to a client who was not confident about meeting with a group of strangers. However, another client was not keen about attending further CMP sessions because so far he had left sessions feeling worse; he felt the practitioner did not understand his situation and the barriers to paid work that he perceived. However, this person was resolved to keep attending to demonstrate both a desire to make progress towards work and a willingness to co-operate with Pathways.

A number of people with appointments, and some without, hoped there would be more sessions or were thinking about what they might do next. Some of those hoping for further individual meetings were not certain this would happen because their practitioner had either cancelled their last appointment or had left and they were waiting for further news of a rescheduled appointment. There were also people who were not yet sure they would be able to access the group workshops they had singled out (such as pain management sessions) because workshops were scheduled according to client demand. Uncertainty about access to further support from CMP was also experienced where the client had been disallowed Employment and Support Allowance following the Work Capability Assessment and was appealing the decision. Some people in the area where individual appointments and a range of group workshops were offered were thinking about trying group meetings (having attended only individual appointments so far), or were thinking about contacting their practitioner again to discuss a newly developed health condition.

4.4 Non-attendance

4.4.1 Levels of non-attendance

In each area, CMP managers and/or practitioners were concerned about the level of non-attendance, either from referral or subsequently during the course of the programme. Estimated drop-out rates ranged from 20 to 40 per cent. Non-attendance at group workshops seemed to be higher than for that of individual meetings, and a trend had developed in one area in particular (and was noted by many of the clients in this research) such that people would attend the initial sessions but leave before the programme was complete. In this area, one set programme of group sessions were delivered and it could be interpreted that clients who perceived no personal benefit from attending these sessions chose to drop-out because there were no other support options available. Also in this area, the distance travelled by some clients to take part in CMP may have contributed to the drop-out rate. Clients who commented on the group size diminishing over

time thought that those who dropped out had deep-rooted problems. They could also see advantages in being left with fewer group members as this allowed each individual more time to contribute and to discuss issues specific to their lives. One view from a CMP manager was that once people had started they tended to stay and non-attendance was more of a problem between referral and starting the programme. There were also some Pathways advisers who felt that few dropped out of CMP because of the practitioners' skills in building rapport with clients.

Some CMP providers had developed strategies to reduce drop-out rates or to mitigate the effect of non-attendance on delivery. Pathways advisers in one area said that when they talked to people who were thinking of taking up CMP they stressed the cost and quality of the intervention and this seemed to be encouraging people to attend all available sessions. One provider deliberately over-booked group workshops and some providers contacted participants the day before as a reminder. In the area where the provider had remodelled their programme, attendance had subsequently improved and this was attributed to a shorter programme duration and having people stay together in a group from start to finish with continuity of support.

4.4.2 Reasons for missing appointments or ending attendance

CMP managers and practitioners identified many reasons why their clients had missed appointments or had stopped attending altogether. These reasons can be categorised as those relating to individuals' attitudes or characteristics, those linked to the structure and delivery of CMP, or those relating to external barriers to participation. This sub-section also draws on data from the few people in this research who ended participation in CMP part-way through the programme, and from people who missed the occasional appointment.

Individual attitude or characteristics

Some CMP managers and CMP practitioners argued that people's attitudes and characteristics could be primary reasons why they dropped out of CMP at an early stage. They described how some individuals who had left had lacked self-belief and determination to overcome barriers to work and, consequently, had lacked motivation to attend. There were also people who did not seem to understand that CMP's aim was to help **manage** conditions rather than **treat** them and had left when their high expectations were not being met. Finally, there was evidence in the practitioner and client data that some people's health had hindered their continued engagement with the programme. Practitioners said that people who seemed happy attending CMP but then suddenly stopped tended to have multiple health problems. There were clients in this research who missed appointments but did not drop-out because their established health condition worsened temporarily or because they became unwell due to another short-term illness. One person stopped participating in CMP due to worsening health. Forgetfulness was also used by practitioners to explain missed appointments, which tended to occur in people with mental health conditions and was considered to be a symptom. Staff

also mentioned that some people found participating in a long programme (i.e. 12 weeks) with 'homework' too tiring and this may have contributed to early exits. It was suggested that Pathways advisers were not adequately informing people about what participation in CMP would entail, which might explain why people took it on when they were not well enough to do so, or why they had unrealistic expectations.

CMP structure and delivery

In one area in particular, CMP practitioners and managers believed that the long waiting times to start CMP were significant in the high drop-out rate between referral and assessment and between assessment and starting sessions. According to some CMP practitioners, inappropriate referrals accounted for some non-attendance, where people did not seem to want to be involved (and were perceived to have agreed to CMP to please their adviser) or where people did not appear to be ready for it and were a long way from starting work. Views from Pathways advisers were that it was possible to misgauge clients' attitudes (where it later transpired that the client had not really wanted to attend CMP) or to promote CMP heavily to people who turned out not to be physically or mentally ready for it. One practitioner suggested that some clients with mental health problems were uncomfortable with the particular 'therapeutic process' used in individual sessions. Although none of the clients in this research explicitly said they finished CMP because of negative therapeutic experiences, there were people who found it unhelpful to look back on their past during the CMP sessions and sometimes reported feeling more depressed when they left CMP than beforehand (see Section 4.1.2). There were also perceptions that the Pathways agenda to help people move towards work, and the way this was perceived to have been manifested in tough company targets, did not sit comfortably with some clients who felt they were not ready for work and could have a knock-on effect on participation in CMP. This view was apparent among in-house CMP practitioners who noted that their close proximity to the rest of the Pathways programme meant that negative views about Pathways were often applied to CMP also.

Of the people in this research who dropped out of CMP early, most talked about aspects of CMP structure and delivery to explain why they did not continue. In the area where a set programme of group and individual sessions were delivered, a client had decided not to attend CMP after the initial assessment, mainly due to feeling uncomfortable about the idea of joining group discussions. Further to this, some people explained that they discontinued participating in CMP part-way through because they were not satisfied with what was being delivered and thought it was not worthwhile. Both criticised the programme content for being too simple, 'patronising' or 'weird' and not relevant, especially where their primary health complaint was physical. Other complaints centred on practitioners being inadequately experienced to offer advice regarding medical conditions, and on feeling physically uncomfortable spending hours in rooms too small for group sessions.

So far this section has explained why people **chose** to leave CMP early. However, another reason for early departure cited by practitioners was changes in benefit entitlement, such as losing entitlement to Employment and Support Allowance, which meant the client was no longer eligible for Pathways and CMP support.

External reasons

CMP staff and clients explained how other commitments or events in people's lives could hinder engagement in CMP temporarily or on a long-term basis. Examples were needing to deal with family or housing problems or to look after an unwell child. One client who took part in the research study was bereaved during CMP and felt unable to return for further appointments. Some people explained that one of their CMP sessions had clashed with something else important, such as an appointment with a health professional or a training course set up by Pathways, and they had had to miss CMP as a result.

The need to travel some distance to CMP, requiring a lift or public transport, was also considered by practitioners to be a barrier to continued attendance, despite the offer to reimburse the financial cost. Some clients in this research study talked of how they found travelling to CMP an effort but had not stopped attending as a consequence.

4.4.3 Staff responses to non-attendance

In general, CMP practitioners in each study district followed similar steps in responding to non-attendance. If the client had not been in touch to explain their absence, CMP practitioners' first action was to attempt contact with the client directly, by phone or letter. Analysis of the client data showed that if people did not explain their non-attendance in advance or after the event, someone from CMP would be in touch, sometimes at regular intervals until the client returned to the programme.

When contact with the client was achieved, it often became apparent to practitioners that the client had been unable to attend their appointment, or had forgotten, and wanted to continue participating in the programme, so their appointment was rescheduled. A number of clients who had missed group sessions described how they were asked to join a different group to catch up, or were offered an individual meeting to cover the material they had missed.

However, if the client did not want to return they were asked to sign a form to formally leave the programme, or complete a questionnaire, and were signposted back to their Pathways Adviser. Some practitioners felt it was important not to rush this leaving process, or to ask the client's adviser to keep their 'file' open for a month or two, because some people changed their minds in the meantime and wanted to stay on CMP. Indeed, one practitioner said that she might attempt to re-engage the client with the programme by using the client's personal action plan to see what had changed. And some clients in this research study who left CMP midway through recalled that a member of CMP staff had phoned and

either asked them to return, or informed them about another element of the programme that they might find beneficial.

CMP practitioners explained that they would get in touch with the client's Pathways adviser if they were unable to make contact with the client themselves. They would check whether the adviser had been in contact with the client and whether they knew of any reasons for the client's non-attendance. In some cases practitioners would ask advisers to get in touch with the client to find out why they did not attend and to explore if any other support would be appropriate. There was limited data on whether advisers played a role in encouraging clients to re-attend CMP, but one view was that if people dropped out because they had found it 'too much' for them, advisers would respect this view and would not talk about CMP again.

4.5 In-work support

Analysis of the data suggests that in-work support was offered as part of CMP in some of the districts studied for this research. In these areas, CMP was delivered in-house by clinicians offering support specific to either mental or physical conditions (as well as group workshops in one of these areas), for a maximum period of either six weeks or six months. Practitioners explained that in-work support was designed to check how the client was managing at work and provide the client with someone to talk to about any problems or with advice about adaptations, equipment and ways to manage pain. In one area, in-work support also included an extended gym membership and the possibility of hands-on treatment for physical problems that might otherwise force the client to leave their job.

One client in this research had attained paid employment at the time of the research interviews but had not yet started the job, so had no experience of in-work support from CMP. This person hoped that meetings with the CMP practitioner would resume while waiting for the job to start. In addition, another client knew about the availability of in-work support but wished that more support from CMP was available in preparing for work.

4.6 Staff experiences of support and supervision

As the CMP is designed for people with health conditions who may be in distressing situations, practitioners are likely to need skills or experience in dealing with vulnerable people and with a range of health conditions. In fact, a number of clients expressed their concern for practitioners because they seemed to have little warning of the clients and problems they would be dealing with. Therefore, it is important to explore the support available to CMP practitioners, and the level of supervision managers use to ensure high quality and ethical service provision.

In all areas, practitioners working on the frontline attended regular supervision meetings with their manager or a senior practitioner. The purpose was to check

how the practitioner was getting on with their current caseload and talk through any perceived problems. Sometimes supervisors chose to sit in on practitioners' sessions with clients to observe more closely their handling of clients and their situations.

In addition, practitioners who had undergone clinical training or were counsellors had experience of clinical supervision. This meant that clinical supervision was experienced by at least some practitioners from all but one of the CMP providers included in the study. Clinical supervision was distinct from other supervision because it was based on the practitioner's specialism (i.e. occupational therapy or psychology) and conducted by a more senior health professional sharing the same specialist training. It was intended to support health professionals by providing guidance to aid clinical judgment. Arrangements for clinical supervision differed according to seniority, with some practitioners supervised internally by a senior practitioner or manager, who were themselves supervised externally. For the senior practitioner in one area, external supervision was mostly, but not entirely, subsidised by the CMP provider organisation.

All CMP providers had implemented regular group meetings for all their practitioners. Mostly these were used as case conferences to discuss specific cases and develop shared learning about procedures and effective ways of helping people. In one area the CMP manager felt that group meetings were not useful because they were not client-focused and were concerned instead with discussing administrative and procedural issues. However, in this area and in all others, practitioners described sharing supportive relationships with their colleagues centred on informal contact.

Extra forms of support and supervision were in operation in one of the in-house CMP providers. Firstly, operational managers carried out individual performance management reviews at regular intervals which were in addition to formal supervision by senior CMP practitioners and managers. During these reviews, managers compared practitioners' performance against targets (for example, the number of one-to-one or group sessions completed over a period of time), discussed client feedback and gave advice about procedural matters. One practitioner explained that there was no conflict between this operational review and the health-centred discussions held with clinical supervisors. Secondly, cross-disciplinary meetings were organised between practitioners serving the same office(s), to discuss clients with both mental and physical health problems and put together group workshops serving both client groups.

At the time of the research interviews some CMP practitioners and managers were satisfied with the level of support and supervision available. In particular it was important to have open access to, and dialogue with, managers; to be supported as needed by colleagues; and to have opportunities for skill retention and development. In one in-house area, practitioners (who were clinically trained) expressed a desire for more supervision and a practitioner felt that the psychological therapy they had chosen to undergo should be paid for by the CMP

provider organisation. Another clinically trained professional from another provider thought that externally-run training, paid for by the provider organisation, would help practitioners to keep up to date with specialist knowledge and techniques.

4.7 Summary

This chapter has explored in detail practitioners' experiences of delivering CMP and clients' experiences of attending CMP sessions.

Although the programmes in each of the four study areas were designed and delivered differently, there were key similarities in study participants' accounts of what happened during CMP sessions. Thus, in one-to-one sessions and most group workshops there was a general introduction, opportunities to discuss problems and learn more about their roots, information and advice about condition management techniques, written information about health conditions, goal-setting and encouragement to work on problems or fears at home, and time to feed back about progress and review next steps.

There was agreement among CMP staff and clients that the way practitioners behaved (for example, being open, honest, understanding, non-judgemental) and the expertise they demonstrated were critical factors in building rapport with clients and for clients perceiving sessions as helpful. The approaches adopted during sessions were also thought to be important, with practitioners and clients favouring individual and holistic approaches to assessing needs, developing coping strategies and reviewing progress. Although there was evidence that individually tailored support was particularly helpful, this did not mean that group workshops were an unhelpful exercise, as they could provide opportunities for people to meet others in similar circumstances and encouraged mutual support between group members. Thus it seems that the areas that offered both group and individual sessions were able to meet more needs.

Although there was little empirical evidence of experiences of delivering and receiving in-work support, CMP practitioners who were involved in delivering it were positive about its value in helping people to sustain work over time.

Regarding what was perceived as not working well or unhelpful, the location of CMP sessions and the facilities were criticised by people who had to travel far, or by clients and practitioners who felt the rooms used were too cramped, noisy and did not protect privacy. CMP was considered to leave some people's needs unmet where people had severe health conditions or multiple barriers to work, or where their health problems were primarily physical. Negative interactions with staff and uncertainty about practitioner expertise and the 'therapeutic' approaches they adopted were also highlighted as unhelpful aspects of CMP.

Three subtly different approaches to focusing on work within CMP sessions were described by practitioners and managers, ranging from being driven by a focus on work to introducing work when this seemed appropriate for the individual client.

The extent to which clients acknowledged the same strength of focus on work and responded positively to it depended on how motivated clients were to return to work. Thus people who were looking for work-oriented support were happiest when work seemed the main focal point of sessions; people who wanted to put health and other aspects of well-being before work (at that time) were satisfied when they perceived work as an underlying or ultimate aim, but could feel under pressure when they felt that discussions about work were too prominent. It appears that, for people who were not ready to think about work, discussing work could sometimes affect continued engagement in CMP and hinder personal progress.

There was concern about high levels of non-attendance in all study areas. Findings showed that non-attendance could be explained by individuals' attitudes (such as a lack of motivation) or circumstances (such as deteriorating health), CMP structure and delivery (for example, long waiting lists or finding session content irrelevant) and external barriers (such as travel problems). These findings raise questions about how people who cannot engage with CMP can be helped by Pathways or other services.

Some clients were concerned about the welfare of CMP practitioners because they had to deal with clients and their problems without knowing what to expect. CMP managers and practitioners described various forms of staff support and supervision, which was found to be particularly helpful where there was open access to, and good dialogue with, managers, and where colleagues were able to support each other. However, a need for more clinical supervision was expressed by some practitioners with clinical backgrounds.

Themes to be discussed further in Chapter 7 are:

- the value of individually tailored support and encouraging solidarity between CMP attendees using group sessions;
- the importance of CMP practitioners being able to demonstrate expertise and empathy;
- the implications for client attendance and engagement of long waiting lists;
- providing help to people who feel unable to engage with or keep attending CMP;
- the implications for client engagement and progress of focusing on work within CMP sessions;
- the extent to which CMP meets people's needs;
- the potential for in-work support to play a role in CMP and in keeping people in work.

5 Linking CMP to other Pathways services and support from other sources

Given that CMP clients might be expected to have complex and (potentially) unmet needs, this chapter considers the end of CMP sessions and whether CMP clients are signposted to other forms of support by CMP practitioners and Pathways advisers. Section 5.1 considers CMP practitioner and client experiences of the end of CMP before Section 5.2 looks at whether Pathways advisers had been in contact with CMP clients during their CMP sessions. The working relationships between Pathways advisers and CMP practitioners are discussed in Section 5.3 and Section 5.4 considers whether CMP clients had other sources of support to draw on. CMP manager and practitioner experiences of signposting clients to other services are discussed in Section 5.5. The chapter concludes with a summary of the main points in Section 5.6.

5.1 The end of CMP and the final session

This section considers the views and experiences of clients, CMP staff and Pathways advisers about the end of CMP. Some clients were still attending CMP sessions at the time of their research interview (see Appendix A). This subsection therefore considers data from only those clients who, for whatever reason, were no longer attending any CMP sessions at the time of their interview.

CMP clients gave a number of different reasons for having stopped attending CMP sessions, each of which will be discussed in turn:

- CMP sessions had come to a planned end;
- CMP contact had been curtailed because the practitioner had left their employment;
- clients had decided not to return to CMP.

Some people were no longer receiving CMP because their allotted number of sessions had come to an end. The process for people in such cases had usually entailed attending the specified number of CMP sessions and having known in advance when their final session would take place. This was not the case for all clients, however, and some of those who had finished their CMP sessions had in effect had their contact curtailed or had finished CMP before reaching their allocated number of sessions. The main reasons for this seemed to be staff turnover, and it was common to hear that clients would turn up for a session to be told that this was in effect their last session with the CMP practitioner as they were leaving. It was also usual in such instances for clients to refuse the offer to see another CMP practitioner where they were given it. Reasons for refusal included not having that many sessions left to go and not wanting to start all over again with a new practitioner. In such cases, some people felt that it would have been helpful to have had more warning that the practitioner was leaving. Some other reasons given by people for (sometimes suspending and leading to) terminating CMP sessions was ill health and bereavement. Some other people said that they had left CMP after a few sessions because they had not felt it useful or relevant to them in their situation. Clients' reasons for leaving CMP part-way through the programme are discussed in more detail in Chapter 4.

A key theme arising from both clients and CMP practitioners concerned the assessment, and discussion, in the final CMP session of the progress which had been made since the start of the programme. In the main, the assessment of progress seemed to have been carried out by the completion of the same questionnaire in the final CMP session as had been completed in the first CMP interview. This progress was usually, but not always, discussed by the client and the CMP practitioner and some clients reported being asked to think about what it was in particular they thought had allowed them to make progress. Some also recalled having been asked for their opinion on the CMP course and others recalled providing either verbal or written feedback, including, in some cases, feedback on how the course could be improved.

Some clients who reported that they had finished their CMP sessions had not had a final session, as such. This was the case, for example, where clients had decided that CMP was not appropriate for them and had telephoned CMP staff to tell them that they were not going to return to any more sessions. This was also the case where people might have attended all of their CMP sessions but were not well enough to participate in the final group session. It is worth noting that in one area where there were several components to CMP provision, there was a perception among some clients and CMP practitioners that there was no clear cut 'ending' to CMP. Some of these people reported that while their counselling or learning sessions had ended, they were still attending some activity-based group meeting such as a walking group or a Pilates class.

Mostly people spoke in positive terms about their final CMP session where they felt and could recognise that they had made progress and were able to discuss

this with the CMP practitioner. Some of these people said that they had also felt sorry or sad that their CMP sessions had come to an end, because they had found them beneficial and worthwhile and would have liked to continue with them. There were other people who had enjoyed their CMP sessions as a whole but had recalled a more upsetting final session. In one such case a client had been asked to sign consent sheets retrospectively agreeing to all of her previous CMP sessions and thought that it might have been better to have been asked to sign these at the time the sessions took place. This person also felt that her final session could have been used for some more useful purpose.

Other clients spoke of being quite upset when they had turned up for a CMP session with their CMP practitioner and had been informed that the practitioner was leaving their job and that this would be their last session with them. In such instances this transpired as being the client's last CMP session because they often could not face the thought of starting again with a different practitioner for the (sometimes few) remaining sessions. This might have been particularly so where the client had been able to open up emotionally to the CMP practitioner. In some of these cases clients had felt rejected or let down. CMP practitioners reported that some clients found the end of their CMP quite difficult to come to terms with and the final CMP session was seen as particularly significant for some practitioners. One spoke of using the session to 'cut' the CMP relationship between practitioner and client while another said that the final interview was key to drawing CMP to a positive close for the client and so it was important to handle this session well. One practitioner said that she constantly prepared people for the end of CMP throughout their sessions by reminding them of their time limited duration.

Most CMP practitioners said that they would either provide feedback about a client's progress to their Pathways adviser or would refer them back to their adviser after their CMP sessions had finished. Some also signposted clients onto other organisations for counselling, addiction services and health care, for example. Some practitioners also spoke about offering clients in-work support which they could take up after their CMP sessions had finished.

Adviser experiences of what happened at the end of CMP sessions were area specific. In one area Pathways advisers did not seem to be sure whether or not they received feedback from CMP practitioners at the end of a client's sessions. In another, advisers reported that they received handwritten reports about clients from CMP practitioners, but that these could be difficult to read and they would prefer to have updates put onto the computer system.

Some clients who had completed their CMP sessions reported that their final session had included a discussion of the next steps that they might take. These included:

- identifying and accessing other courses;
- looking for work with the aid of the Pathways adviser.

Some people said that the CMP practitioner had told them that they could keep in touch if they felt they needed something or if they needed in-work support at some later stage. Others described having a discussion with the practitioner about what they had identified for themselves to do next, for example, a new course. Some clients said that they felt better about CMP ending because they had something else to move onto. Other people reported having discussed with the practitioner what steps towards looking for work with the Pathways adviser they would be taking and some people reported that they had just been advised by the practitioner to continue working with their Pathways adviser. Most CMP practitioners reported that they used the final session to discuss the clients' next steps. In one area where CMP provision was provided in-house, practitioners said that they would also offer to have a three-way meeting with the client and the Pathways adviser to enable the next steps to be discussed between all parties. Advisers in this area also reported that they had three-way meetings with clients and CMP practitioners which were used to plan ahead.

Whilst some people who had completed CMP spoke of maintaining contact with their adviser and other Pathways provision after CMP had finished (for example, visiting the office to use computers for job search activities, or attending courses), some people said that they had heard nothing more from their Pathways adviser after their CMP sessions had finished and that they did not understand why.⁶ One person perceived that it might have been because he was a voluntary attendee at Pathways and were therefore not a priority for the Pathways adviser.

5.2 Pathways advisers contact with CMP clients

Given that CMP forms just one part of the support offered to people through Provider-led Pathways provision, it is relevant to understand whether and how Pathways advisers keep in touch with clients through their CMP sessions. This section outlines clients' and advisers' experiences and perspectives of contact throughout CMP.

Some clients reported having had no contact with their Pathways adviser throughout their CMP sessions. Some of these however, said that they had felt that they could have asked for contact with their adviser had they wanted to. In this respect, advisers in one area recognised that because of the delay in clients accessing CMP it was often difficult to combine the timing of work-focused interviews with CMP interventions. For example, an adviser explained that a client being referred for CMP in their first or second work-focused interview might have finished their series of five interviews by the time they accessed their first CMP session. This could make it hard to amalgamate CMP health advice with removing other work-related barriers in the work-focused interviews. However, Pathways advisers in this area said that they could defer contact while people were on the

⁶ The timing of research interviews might be relevant here, as people might have been followed up at a later date by advisers.

waiting list for CMP. Doing this, and picking up with the client once CMP started was seen by advisers as good time management and a way to use the clients' remaining work-focused interviews to concentrate on getting people work ready.

Advisers in two areas reported that referring a client for CMP made no difference to the way in which work-focused interviews or appointments were made with them. Staff in one of these areas perceived that they were not allowed to defer their work-focused interviews with clients on the grounds that the client was attending CMP sessions.

Of the clients who reported seeing their Pathways adviser throughout their contact with CMP, one person said that she had met with her adviser after every CMP session to discuss her progress and to complete work-related activities such as constructing a CV. Another client said that his adviser found jobs for him to consider and presented these to him in between their CMP sessions. One other person who was still attending CMP sessions said that his adviser was currently looking for a work placement for him and was also helping him to send his CV to prospective employers. Other people spoke of having arranged with their adviser to do classes or courses alongside their CMP sessions.

Advisers in one area reported mixed approaches regarding whether or not they saw clients on CMP. In this area advisers had experience of people coming back to see them on a voluntary basis (and then getting into work) because they had finished their five mandatory work-focused interviews and were still attending CMP sessions. Some advisers recognised a potential benefit between overlapping CMP and work-focused interviews and one experience was to see clients straight after their weekly CMP appointment so that discussions about work could be linked with progress made during CMP.

5.3 Working relationships between Pathways advisers and CMP practitioner staff

Advisers were asked to discuss the nature of their working relationships with CMP practitioners, thereby revealing the key aspects of good relationships and reasons why some relationships did not work so well. In one area, an adviser thought that poor communication and a lack of contact at the beginning of CMP had perhaps led to low referral rates at the start because advisers lacked understanding about the nature of CMP. This was not so much the case in areas in which Pathways advisers shared physical office space with CMP staff. In these areas advisers and CMP practitioners spoke positively about the benefits of physical proximity for the quality of their working relationships. Some advisers said that physical proximity from sharing a building or office space had led to getting along well with CMP practitioners and reported having discussions about clients and how best to interact with them. Advisers also explained that it helped because both CMP practitioners and advisers had come to appreciate the different pressures that each worked under. Having CMP in-house had meant that CMP practitioners

were able to explain to advisers what was on offer from CMP and to whom it should be offered. In these in-house providers, CMP practitioners were seen to be very effective at feeding back about clients to advisers.

Similarly, CMP practitioners considered that sharing an office led to good and open communication which kept advisers and practitioners connected. Collaborative working had occurred, for example, when a CMP practitioner had been invited to chat with a client because the Pathways adviser was not sure whether they were suitable for CMP, when practitioners informed advisers about any changes in a client's work readiness, and when practitioners felt able to get involved in work-focused interviews to discuss the benefits of work. One practitioner said that she worked with advisers in order to 'up skill' them for their dealings with clients: for example, educating advisers about who to signpost to other organisations, how they might best engage with clients, and what kinds of workshops might be appropriate for people. In one area, CMP practitioners said that they worked with Pathways advisers to improve their understanding of CMP and so receive more appropriate referrals from them. Some CMP practitioners perceived that the relationship they had with advisers was on a personal level and said that they understood the way that advisers were under pressure from business targets. Some also felt able to discuss with advisers instances where they felt that their CMP clients were either being placed under too much pressure to find work, or where they were being led to consider work that was not in line with their employment aspirations, for example where a client wanted an administration job, but was being asked by the adviser to consider taking a cleaning post. This respondent also talked about supporting advisers in their role of dealing with vulnerable people.

Trying to engender increased communication was a key theme from managers. A sub-contractor manager in one area felt that the physical proximity of advisers and CMP practitioners led to a reduction in the number of inappropriate referrals by advisers, but said that communication was hampered by the amount of work advisers had to do. They also felt that more formal communication was needed at the time people completed CMP and were handed back to the Pathways adviser. There were some problems in communication noted in one area with a provider failing to notify CMP practitioners when clients had exited the provider. One manager reported having used the IT system to increase communication between CMP and Pathways staff. Advisers were subsequently informed as to whether or not clients had attended their CMP sessions and also received an outcome report for each client who had completed, or dropped out of, CMP to assess whether their job readiness had increased. Another manager reported that CMP providers and advisers held case conferences to determine which elements of CMP might be suitable for which clients. They said that they thought it was beneficial when CMP practitioners helped Pathways advisers to understand the aims of CMP, which clients might be suitable for it and educated the advisers on health conditions.

Practitioners in the area which did not share physical proximity with advisers described some tension between advisers and CMP practitioners (although they also spoke about understanding that advisers worked to targets whereas CMP practitioners did not). Some noted that they did not always feel as though they got co-operation from advisers to provide a professional service to clients. Instances of inappropriate referrals were partly thought to stem from advisers not paying attention to information given by CMP staff on the training day. A sub-contractor manager in this area said that CMP practitioners coming into the Pathways office to see clients helped foster communication between CMP and Pathways advisers and so helped to resolve any questions about referrals.

In many ways, Pathways advisers and CMP practitioners felt that greater organisational harmony had begun to develop between them. This was significant because they either worked for different organisations (where CMP was sub-contracted) or were accustomed to different cultures of working; this was portrayed as the difference between business and healthcare, or between non-clinicians and clinicians. Achieving shared purposes, ways of working and effective communication were important for Pathways advisers in acquiring knowledge of CMP and advice about dealing with people with health problems in general. For CMP practitioners the benefits were seen in high rates of appropriate referrals, understanding how CMP can link up with other Pathways provision and signposting/referring people to Pathways provision with more confidence. There was also a view that a shared culture and agenda throughout Pathways and CMP demonstrated to clients that staff were working together to provide holistic support in a seamless fashion. The data suggest that one of the best ways of instilling collaborative working was for Pathways and CMP practitioners to share office space. Administrators were also thought to be important in encouraging clear and regular communication between Pathways advisers and CMP practitioners.

5.4 Client experiences of support from other sources

Support received from other sources might be expected to make a difference as to how important CMP, and the wider Pathways provision, might be to clients. It is possible, for example, that CMP might be particularly beneficial for people with very limited social networks and/or who are not receiving any health interventions. That said, some people with strong social networks might also gain valuable benefit from taking part in CMP.

Some CMP clients reported that they had very little or no support network by way of either family or friends and that they were receiving little or no health care outside that offered by CMP. Others reported that they were receiving minimal support, or were awaiting the promise of support. For example, some people with virtually no support networks had been referred by their GP for counselling and were on a waiting list or had been prescribed only medication to help deal with their mental health condition.

Some people reported having only limited support from other sources. Some were receiving helpful medical interventions from hospitals and GPs and others reported that while their social networks were strong, they had received very little help from health care or other services. Other people had a number of valued sources of support on which to draw with some people reporting that they had very strong social and familial networks and had received excellent health care from their GP and NHS healthcare services.

Other sources of support which clients felt would have been helpful at the time of their CMP intervention included:

- more support for family issues;
- a less disabling built environment, for example accessible premises.

Some people had said that having had their health condition explained to them by CMP practitioners in 'layman's terms' and of learning more generally about their health condition and about healthy living had been very helpful to them and had not been something they had gained from any other source (see Section 4.1.2). There were also people who felt that other support had been more beneficial to them than CMP (see Section 6.2.4).

5.5 CMP practitioners' experiences and views of signposting clients to other organisations

Given the differences in support that people were able to call on, and the unmet need that some clients voiced, it is important to understand CMP practitioners' experiences and views of signposting clients to other services and organisations for help.

CMP managers and practitioners talked about signposting people who had been referred inappropriately to CMP to other organisations and services. They also spoke of signposting clients with severe needs who were not thought eligible for CMP to their GPs as well as to Improving Access to Psychological Therapy.⁷

Some practitioners spoke about having an ethical duty to signpost clients referred for CMP who they could not help to other organisations and services such as NHS services and third sector organisations such as the mental health charity, Mind. However, some practitioners thought that it was unethical to refuse someone with severe needs access to CMP if they wanted to attend and were highly motivated.

Managers also said that CMP clients were often signposted for counselling, to mental health and befriending groups, exercise classes, and said that they would

⁷ Improving Access to Psychological Therapies is an initiative that has been funded by the Government to increase the number of trained psychological therapists and so improve availability and speed of access to 'talking therapies' for common mental health problems (mainly anxiety and depression).

advise people with drug and alcohol problems to go to an appropriate programme. One person stressed that he did not see it as the role of CMP to **refer** people because that would be assuming clinical responsibility for their health, which was the role of their GP.

Managers and CMP practitioners reported a number of difficulties which were encountered in signposting CMP clients to other organisations. These included the limited availability of low cost or free counselling services and locating information about available services in the local area. Some services were considered by managers to have very specific eligibility criteria which were hard for a lot of CMP clients to meet. In one area, managers were trying to develop partnerships with external organisations and to find out about voluntary organisations so that they could signpost clients more appropriately. They also spoke of having contacts in the NHS. Similarly, some practitioners noted that finding out about the services and organisations which might be available in their areas could be difficult and some did not have very much time to do this. Gaps in provision were mentioned by some CMP practitioners, specifically for support groups that work with people with psychosis and their families. One perception was that the biggest improvement in CMP would come from finding low cost and affordable services to refer people to. Another practitioner said that it could sometimes feel as if they were signposting people to voluntary services which were already overstretched.

5.6 Summary

This chapter has highlighted that for some clients the ending of CMP sessions can be emotionally upsetting, especially where their sessions are terminated early and they had little notice, for example when CMP practitioners leave their employment. The data also suggests that the structure of CMP can also affect the degree to which clients could experience the ending of CMP as either more or less 'sudden'. The least abrupt ending to CMP might be where, as in one area, modules are designed to run on for long or indefinite periods.

The data also showed differences in how, and if, clients were 'handed back' to advisers after their CMP sessions had finished. In some cases this was done by written means, but in one area in which CMP was provided in-house, CMP practitioners said that at the end of clients' CMP sessions they would offer to have a three-way meeting with the client and the provider adviser to enable the next steps to be discussed. Analysis highlighted variation in whether Pathways advisers attempted to continue clients' work-focused interviews during the time they were taking part in CMP.

Throughout the chapter the findings have highlighted that physical proximity between CMP providers and Pathways advisers seems important in a number of different ways, but especially in improving working relationships, communication, and an understanding of the respective roles between Pathways advisers and CMP practitioners.

The penultimate section of the chapter highlighted that some CMP clients were immersed in strong social and health-related networks, but that others had virtually no support at all. Some CMP practitioners spoke of the difficulties which might be encountered in signposting CMP clients to other services. These included the limited availability of low cost or free counselling services, and problems identifying information about appropriate local services.

The discussion in Chapter 7 will return to the following themes:

- the implications of CMP practitioner staff turnover for the client's experience of CMP;
- the implications of the structure and design of CMP for client experience of the end of CMP;
- the efficient handover of clients from CMP practitioners to Pathways advisers;
- the timing of work-focused interviews and CMP sessions to maximise the benefit of support for clients;
- the importance of physical proximity between CMP practitioners and Pathways advisers;
- information about, and the availability of, appropriate provision to signpost clients to.

6 Views on the impact and performance of Condition Management Programmes

This chapter presents the views of Pathways advisers, CMP managers and practitioners and clients on the impact and performance of CMP. The chapter starts in Section 6.1 by explaining how CMP staff recorded and measured programme performance and sets out their overall impressions of performance so far. Section 6.2 concentrates on clients' (and to a smaller extent, staff members') perceptions of the impact made by CMP, before the duration of CMP impacts is explored in Section 6.3. Staff and client suggestions for improvements to the programme are discussed in Section 6.4 and clients' perceptions of ongoing barriers to work and support needs are reported in Section 6.5. A summary of the chapter appears in Section 6.6.

6.1 Staff experiences of monitoring performance and overall impressions of performance so far

Two of the Pathways districts studied in this research had started implementing Pathways to Work in December 2007 and two had commenced the programme five months later in April 2008. Comments from Pathways and CMP managers in the two latter areas suggested that (at the time research interviews took place between March and May 2009) it was too early to assess staff and programme performance with any accuracy because few clients had completed the programme and it was still being developed. There were also signs that providers were only just starting to use targets and performance indicators. Despite this, managers and practitioners in all areas were able to offer some useful data about how client progress was, or was planned to be, monitored and programme performance reviewed.

It is important to note that in three of the four areas the aim was to achieve 'soft' outcomes of some kind, such as improvements in health, confidence or readiness for work. However, one Pathways provider had just imposed a job outcome target on its CMP sub-contractor. Practitioners who were now tasked with helping 15 per cent of their clients into work did not welcome this target, arguing that they had enough to do to help clients without looking for jobs and that it was really the role of Pathways advisers to achieve job entries. Some practitioners who did not have job outcome targets thought it was important that they were not seen to be pushing people towards work, which might happen if they had such targets.

Client progress in achieving 'soft' outcomes was monitored and measured by some providers using a formal method of assessment such as the Hospital Anxiety and Depression Scale, or Occupational Self Assessment. Progress was assessed by measuring certain indicators (for example, perceptions of health and readiness for work) at the start of CMP and when the programme was completed. In some areas, action plans and activity diaries were the main tool used to collate evidence of change in clients over time. In areas where practitioners worked with individuals over a number of sessions, observation notes were also helpful in determining whether clients had made progress. Keeping track of client progress was often important because it formed a major part of managers' evaluation of staff performance. 'Soft' outcomes were not usually targeted, except in one area where making progress on the health assessment was the subject of a target. This target was perceived by practitioners as easy to meet because, for most people, just having some kind of therapeutic intervention brought improvement.

CMP practitioners often had targets for procedural performance, such as retaining a percentage of clients who start CMP throughout the length of the programme; conducting a certain number of assessments per month; holding a certain number of individual appointments and group workshops per month; and attaining a certain level of attendance at sessions. Some practitioners thought their procedural targets were generally manageable, save for exceptional circumstances when practitioners were on annual leave or off sick. However, the target to hold 69 assessments per month for one provider seemed too high given that there was a shortage of rooms to meet with clients and the fail-to-attend rate was high.

In addition to gathering data about client progress and to measure against procedural targets, some managers and practitioners mentioned that a variety of management information was collected. Across the four districts, this included information about age and gender of participants, the number of referrals, the number of initial assessments, the number of starts on the programme, the number of instances where people failed to attend, and the number of people who completed CMP. There was a suggestion that this management information was recorded but not necessarily used (yet) to inform performance evaluations.

Regular checks on clinical governance compliance (ensuring, for example, high standards in storing client records and obtaining consent) were said to have been conducted by representatives from the Department for Work and Pensions (DWP),

by one Pathways CMP manager. The Pathways CMP managers in areas where CMP was sub-contracted described how they evaluated their sub-contractor's performance by sitting in on CMP sessions and/or using the DWP Quality Framework and Self-Assessment.

A final method for monitoring and reviewing programme performance in most, if not all, areas was to gather client feedback in some way. This was achieved using evaluation questionnaires and/or verbal feedback given in exit interviews or communicated to other Pathways staff.

Overall, managers and practitioners were positive about CMP performance so far, sometimes stating how clients generally seemed happier and healthier after taking part. Some advisers described how some clients could make dramatic transformations from having very low self-esteem to feeling excited and motivated about getting a job, for example. Pathways advisers who had very positive impressions of CMP thought it was invaluable because it dealt with underlying problems that were holding people back, it reminded advisers that people had health problems that needed addressing, and (in areas where CMP practitioners were health professionals) it gave Pathways credibility as a programme to meet people's needs. One in-house CMP manager thought it would be unethical to try and encourage people into work without considering their health needs and, therefore, that CMP (by focusing on health matters and work) 'made Pathways possible'.

However, one Pathways CMP manager said that the CMP sub-contractor was not performing to expectations regarding the number of CMP clients moving into work. The manager expected job outcome performance to improve now that a target had been put in place and now that CMP practitioners had access to the Pathways database containing information about advisers' discussions with individuals and agreed plans.

6.2 Impact on CMP clients

Clients in this research study were asked for their views on the difference CMP had made for them. To assist analysis of impact, clients were also asked for details of their health and employment situation prior to starting CMP and at the time of the interview. Analysis of the client data suggests that the following impacts were perceived:

- CMP initiating progress towards work;
- CMP enhancing progress towards work;
- CMP improving well-being;
- CMP making limited impact, no impact and negative impact.

It should be noted that this analysis includes some people who had attended several CMP sessions and were still taking part in CMP (and therefore whose views about the impact of CMP could change with further participation). However, the

analysis excludes one person who only completed one CMP session and one person who only attended a CMP assessment.

6.2.1 Initiating progress towards work

Analysis showed that some people had either taken steps towards paid work or developed plans for work-related activities since starting Pathways or CMP. A client who had been searching unsuccessfully for work before starting CMP had since been offered a voluntary work placement and then been successful in applying for a full-time paid job. Some others had started to look for a job, though one person had stopped again upon realising that he was not as well as he had initially thought. Other steps taken were starting a course that would provide access to a new career, entering voluntary work, and attending mock job interviews to further prepare for job-search activities. Another client had begun considering seriously the option to try voluntary work. Some of these movements towards, or renewed thinking about, work were significant to people who had not worked for many years and had doubted that they would be able to enter paid employment, or think about preparing for getting a job, while they were still affected (in some way) by health conditions.

Most of these people felt that taking part in CMP had been a key influence in taking steps or changing plans regarding work. They felt that CMP had helped to improve their readiness for work and linked this specifically to the following impacts:

- becoming equipped to deal with a health condition at times of pressure (which had helped one person to complete a work trial and be offered a job);
- feeling less tired and having more energy and motivation to find work;
- feeling more confident about applying for jobs having been given 'tools' to handle the perceived stress of doing so;
- becoming more focused on a certain career path;
- feeling more motivated to take action 'today' rather than 'put it off for tomorrow'.

A slightly different view was held by some people who felt other aspects of Pathways had been equally or more significant in their progress. The person who achieved full-time employment felt that the support from the Pathways adviser had been just as valuable as that from the CMP practitioner. Another client was clear that the motivation gained to sign up for a training course was driven by meetings with the Pathways adviser and that, although CMP was an 'added bonus', this step would have been taken without CMP.

Each of the people who felt Pathways or CMP had initiated progress towards work talked about additional impacts associated with taking part in CMP. It could be interpreted that these impacts, although not explicitly linked by people to their readiness for work, might have contributed to feeling able to take steps or develop

plans for work. Thus, some people noticed that their mental health had improved (for example by finding that feelings of depression were fading) and for some others the improvement was physical (for example by losing weight and generally feeling better through changes to diet and increased physical exercise). New-found abilities to manage conditions and problems were cited, such as feeling able to handle stressful situations, overcome negative feelings and fears, and suppress anger. A variety of other 'soft' outcomes were also mentioned, such as feeling less socially isolated (having made new friends on CMP or having been encouraged to reconnect with existing friends and family), being more relaxed, learning to be more confident and communicate confidently, and gaining self-esteem.

There was also a person who did not feel any nearer to work, but thought that CMP had led to improved confidence to attend a course of group therapy, which was expected to remove the final barriers to work. In addition, some people did not explicitly attribute the change in their status to having taken part in Pathways or CMP but were able to identify impacts that were supporting steps taken or changes in plans, such as improved general health from taking up swimming, feeling more positive about the future and the possibility of working again, feeling equipped to deal with negative thinking and anxiety, and possessing greater self-confidence.

Unsurprisingly, most people who can be categorised as having made progress towards work, held generally positive views about CMP. On the whole, they enjoyed attending sessions and many said that they would recommend the programme to others because they had been helped. CMP had matched or exceeded their expectations, particularly where the impact produced had been much greater than hoped for (for example, finding that doing exercise could make such a big difference to mental health). However, there were also views that the help available from CMP did more to improve mental health than physical conditions and thus did not work on all health-related barriers to work. This was the view of some people whose primary conditions were physical, but who had other problems such as anxiety, which they felt had been significantly helped by CMP.

Making steps towards or into work after being involved with CMP (and Pathways) was also highlighted by some Pathways advisers and CMP managers and practitioners. They noted how some of their clients had moved into paid or voluntary work and linked these changes to people seeing improvements in their health (for example, reducing symptoms of depression, or improving general health by eating healthily and adopting regular sleep patterns), or learning how to manage their condition(s) more effectively (for example, panic attacks). Some CMP practitioners and managers in all study areas felt that the impact of helping people to understand their condition and how to manage it could not be underestimated, as it gave people control of their condition(s) and, with it, greater control of their life. Even where clients had not gained employment they felt that CMP had made a significant impact on some people's job readiness, such that they were searching for vacancies and attending job interviews. Pathways advisers

in two areas suggested that attending CMP could result in people being more motivated and ready to engage with work-focused interviews and the other help available through Pathways.

CMP and Pathways staff recognised that not everyone who went on CMP was affected significantly. Whether or not they were able to help people progress towards work was felt to depend on the following factors:

- The kind and level of the client's health condition: practitioners felt equipped to work with mild to moderate conditions, or non-chronic physical conditions, as these people were perceived as having fewer well-established barriers to work. Also changes in attitudes, behaviour and ability to manage conditions were considered to be achievable with these people within the time available in CMP.
- The length of time people have been out of work: it was said to be much easier to help people who had spent less time out of work.
- Cultural understandings of psychological therapy: one view from practitioners was that clients who felt there was a stigma concerning therapy and talking about problems (such as clients who were British men) were unlikely to engage fully with it.
- The client's proximity to work and level of motivation: people nearer to work in need of 'an extra boost' to remove final barriers were thought to be ideal CMP clients. There was also a view that if people came to CMP already motivated to make changes in their lives then they were more likely to engage and benefit. If people were 'passively motivated' regarding work then CMP could empower people to become active.

6.2.2 Enhancing progress towards work

At the time of the research interviews, some people were continuing to undertake work-related activities (such as searching for paid employment, doing permitted work, voluntary work or training) or continuing to commit to plans for work (such as expecting to do a training course, start a work trial, or return to a job that had been held open) that they had been doing or thinking prior to entering Pathways and taking up CMP. Reasons for not yet realising their plans were not having a diagnosis (and therefore not feeling able to commit to an employer), waiting for surgery, not being able to find appropriate opportunities for work trials, waiting for the next appropriate training course to start, or feeling constrained by advice from a NHS mental health practitioner to focus, for the time being, on other aspects of life rather than work. For these people, CMP had not played a role in initiating these steps towards work, or in changing their thinking about preparing for work. Some people perceived that CMP had made no impact or only a limited impact on them (reported in Section 6.2.4), but others described how their readiness for work had been **enhanced** by CMP, either directly or indirectly.

A direct impact on feeling more ready for work was cited by people who said they felt more confident in general after CMP, and that this had helped boost

their motivation and assertiveness in continuing to look for work, or work trials/ experience, and in asking for help. A range of other positive impacts were also identified by people, which were not explicitly linked to work readiness but could be interpreted as indirect influences that helped to enhance the progress they had already made. Similar to the group in Section 6.2.1, people here saw the following impacts:

- improvements in mental or emotional health;
- feeling equipped to overcome problems by learning 'a toolbox of basic techniques'
- thinking more positively about themselves and their future (for example, improving appearance);
- feeling less stressed and more relaxed;
- feeling more confident and assertive.

Again, people here were generally pleased with their experience of CMP. Expectations had been met or exceeded in cases where people were surprised at the level of support received. Some people said they would recommend CMP to other people, or had already done so, as a place to be listened to, to meet other people and to be given 'another chance'.

Many CMP practitioners and managers stressed that the work they did with participants often did not mean people returned to work, or even started doing anything different, but that it helped to remove barriers and left people closer to being job ready. They identified the value of helping people in the following ways:

- to develop understanding of their health condition(s) and what they are capable of doing with a continuing health problem;
- to overcome barriers to work such as not having appropriate qualifications by helping people to build confidence and motivation to, for example, take a driving test or enrol on a training course;
- to build relationships and adopt a routine to prepare for the workplace;
- to manage pain better, to lead a more active life and start contemplating work again.

This message that people could make progress towards work without undertaking work-related activities or moving into work, was strongly presented by CMP practitioners and managers, particularly in the area where job outcome targets had recently been imposed. One view was that CMP could not be expected to achieve dramatic changes in all clients in three months. It was also stated by one practitioner that while some impacts from taking part in CMP were immediate, some may be delayed till after the client had finished the programme. The staff data suggests, therefore, that what CMP could do was help people to make some progress, which then created potential for more progress at a later time.

6.2.3 Improving well-being

This research study included people who did not describe any impact on their readiness for work, but nonetheless felt that attending CMP had made a difference to their **well-being**. This sub-group was a mix of people who were continuing with efforts or plans towards work, and people who said they wanted to work again at some point but who were not undertaking any work-related activities and had no work-oriented plans at the time of the research interviews. Among the latter, the most common reasons given for not feeling ready for work were not being well enough to do so and lacking confidence. In addition, one client was in the process of moving house and did not feel able to contemplate work-related activities until settled in the new home.

Perceived impacts on well-being included:

- improved confidence, assertiveness and self-esteem;
- increased motivation;
- feeling able to deal with negative thinking, anxiety or anger;
- 'coming to terms' with having a disability;
- renewed hope that a health condition would be improved after being advised by the CMP practitioner to ask the GP for a hospital referral;
- increased physical activity and, with it, small improvements in mental health;
- greater social interaction.

Although feeling no direct impact on readiness to work, these people were largely or wholly positive about their CMP experience and complimented the programme on providing somewhere to meet and not be judged, and having knowledgeable and helpful staff. Their expectations had been met or exceeded because the difference made was far more than they had foreseen, even acting on problems they did not realise they had (such as mental effects of having a long-term physical condition). Some people explained further that they were satisfied because CMP could not be expected (yet) to have altered their health or improved their employment prospects because of personal circumstances, or the stage reached in the programme. Thus one view was that finding a job would be no problem if physical health improved, and CMP was not expected to make a difference to a condition that required surgical intervention. Another person felt it was too early to say whether the programme would have a significant benefit on progress towards work, having completed only a few CMP sessions to date.

CMP practitioners and managers also recognised that some people (often those further from work) could make personal progress because of CMP, but did not necessarily move any nearer to work. A practitioner felt that most clients made at least some progress. Another practitioner summed up this perspective by saying that while some people experienced dramatic change through being on CMP, for

others the impact resulted in simply taking 'a step along a path'. Staff said that the kinds of progress made by these clients encompassed:

- feeling able to 'open up' to someone about their problems, and know that support is available;
- improving quality of life or a desire for greater quality of life, for example taking care over their appearance or feeling that they have gained control over their life;
- becoming familiar with meeting with other people, which may eventually give people confidence to join a training course (it was considered particularly helpful for people with mental health conditions to build social networks);
- increased concentration;
- understanding the treatment received from other healthcare services and ensuring they accessed the treatment they needed.

6.2.4 Limited impact, no impact and negative impact

That CMP made no, limited or negative impacts was also perceived by a number of people in the research study. As in Section 6.2.3, this sub-group included both people who were doing or planning something in relation to work and people who had no work-oriented activities or plans. Some of these people were in similar situations to those described in Section 6.2.3 and talked about similar outcomes, such as improved confidence and assertiveness, increased social interaction and physical exercise, and hope for further treatment through the NHS after a CMP practitioner had helped them to 'kick-start' contact with the GP. Additional impacts were learning about, or refreshing knowledge of, specific health conditions, or having work plans and condition management strategies affirmed. However, the way people described the overall impact centred on feeling that it was **limited**, rather than focused on the positive impacts that had come about. Thus rather than feeling generally positive about their experiences they were left feeling ambivalent or dissatisfied, to varying degrees. These two sentiments were also voiced by people who considered that CMP had made **no impact**.

Ambivalence about personal outcomes often stemmed from people's situations. A client who had felt compelled to attend CMP was not intending to take up more work than she was already undertaking under Permitted Work rules, so had not expected CMP to alter her work situation. Some people talked about how poor or deteriorating health meant that they did not expect CMP to make a significant difference to their health or work status. Another client's view was that his problems could not be resolved through external help but only by helping himself.

People who felt dissatisfied thought that CMP had failed to make a significant impact on their readiness for work or health, or that CMP had had a negative

impact. This dissatisfaction was often linked to aspects of CMP design and delivery. Thus, there were people who perceived that:

- CMP had come too late (after waiting a number of months to start the programme) as significant progress had already been made and they were about to start paid work;
- any potential to make progress was reduced when participation was cut short because the practitioner left the provider organisation, or was interrupted because long intervals were left between appointments;
- the content of CMP sessions was not relevant or useful because it was 'pitched too low', or did not meet specific needs (for example, it did not provide an assessment of individual capabilities and match them to suitable jobs, as desired and expected by the client);
- there was not enough support offered for physical conditions or that the support offered (physical exercises) did not reduce pain;
- sessions did not deliver what was promised regarding helping people to manage health problems;
- support from CMP did not last long enough or was not followed up so any positive impacts on mental health and confidence did not last.

A few people with mental health conditions also spoke of how CMP had temporarily had a **negative impact**. These people had sometimes left group and/or individual sessions feeling more depressed than when they had arrived. This was attributed to attending sessions that they felt concentrated too much on work, feeling under pressure to take a job that would not be suitable or enjoyable, and hearing about other people's problems during sessions.

The data suggests that people who felt disappointed (whether mildly or strongly) had possessed high expectations about the type and standard of help available from CMP, which were unmet. For example, some people shared strong views about CMP not being a 'genuine attempt' to help people with health problems because it was too focused on getting people into work. Another view was that CMP was offering no more help than they were doing for themselves, or than Jobcentre Plus had done in the past (through a Disability Employment Adviser) and that the help was too non-specific and infrequent. Mild disappointment was expressed by someone who felt that questions about depression (such as its causes) had not been answered adequately. A number of people explained that their own efforts and motivation, or other sources of help, had been more influential in helping them make the progress towards work. Other significant sources of help included family and friends, a specialist hospital programme which included discussion of work matters and help to improve a physical health condition, an NHS pain management course, and books about depression and meditation techniques.

Making no and/or negative impacts was also discussed by some Pathways advisers and CMP managers and practitioners. While most CMP practitioners and managers

suggested that it was uncommon for people to leave CMP disappointed, advisers in one area were quite critical of CMP. They argued that clients found session content too basic, untargeted, repetitive and inadequately led by practitioners and as a result they did not feel they had made any progress. Practitioners from three areas linked the times when CMP did not have an impact to clients' personal circumstances and attitudes, to staffing, or to the referral process. Thus, there was a view that CMP failed to make an impact for people with severe health conditions who needed more intensive support than CMP could offer, and for people with low motivation who seemed not to want help. The lack of provision of practitioners speaking the languages of non-English-speaking clients, or practitioners competent in sign language for deaf clients, meant that these clients could not be helped at all. Also, CMP was considered to make no or little impact on people who came to CMP with unrealistic expectations (that had not been corrected before being referred to CMP) about being 'cured' or receiving support indefinitely. Such clients were said to finish CMP disappointed because the programme did not deliver what they wanted, despite practitioners' attempts to rectify misunderstandings about the extent of the support offered.

6.3 Impact duration

It is important to consider the duration of CMP impacts to understand more fully its value to participants. Not everyone felt able to comment on the duration of impact because they were still participating in CMP at the time of the research interviews. What emerged from the data of those who could look back on their experience was that certain impacts seemed more durable and certain aspects of delivery were influential in supporting or hindering the longevity of impact.

Certain impacts seemed easier to sustain over time. Thus a number of people, regardless of their position in relation to work, said that several months after being advised by practitioners they were still eating healthily, exercising regularly and could still remember practical tips for managing conditions or feelings of stress and anxiety. Some people said they had managed to retain a high level of motivation to take or continue steps towards work. Delivering the programme over a long period (and having time to absorb information fully and act on advice), and providing written information and advice, were thought to be particularly important for remembering practical coping strategies. In one area where all CMP participants had taken part in group workshops, some people explained that they were continuing to meet up with people they had met at CMP in their own time.

Some people expected or assumed that the impact would be long-lasting because they had been helped to get started on a plan which should lead to a career. However, there was some evidence that progress towards work was not always sustainable due to the ongoing effects of their health conditions. For example, a client stopped looking for work after becoming more depressed and angry again. This person felt that he had been naive to assume that he would be ready to look for work after a few one-to-one CMP sessions with a psychologist. A client who

had attained paid employment was uncertain about being able to sustain work over time, as he was still affected by a mental health condition. A CMP practitioner and a Pathways manager commented on the value of in-work support in helping people to sustain paid work (for example in providing a suitable desk, or helping the client to split their working day to create adequate breaks), though so far they had few examples to draw on.

People who took part in the four week programme in one area were particularly sensitive to the possibility that CMP impacts were not durable. Thus, some people in this area thought that if they had not started to do something else immediately after CMP to continue improving health and readiness for work, then the impact of CMP would have been short-lived. Further to this, some people said that they had slipped back into an unhelpful routine after CMP sessions ended. It seemed that some people had felt more positive immediately after each session, but had not remembered or thought to apply the information and techniques learned to their life outside of CMP. In short, not all CMP participants had become empowered to deal with health conditions and problems as CMP practitioners hoped they would do (see Section 2.2). Managers and practitioners from this area were also aware of how important it was for CMP to be joined up to other elements of Pathways, so that the momentum gained through CMP could be channelled into further activities that would sustain progress towards work or other life aims. At present there were concerns that people who had been on CMP were not moving into work, and that positive outcomes were dissipating, because the handover back to Pathways was not working well.

Individual life circumstances and competing advice from other sources of help could also play a role in determining whether motivation to make progress towards work continued after CMP. For example, a client explained that the advice from an NHS mental health practitioner to focus on housing rather than work meant that he felt inhibited in trying to make the most of what he had learned through Pathways and CMP.

6.4 Suggestions for improvements

During the research interviews, Pathways and CMP staff and clients were also asked if they thought anything should be changed to improve CMP or the support available to people on incapacity benefits. Suggestions for change were centred on the way CMP was operationalised or managed and the content and delivery format for CMP sessions.

6.4.1 Changes to operational and management matters

The following were suggested as areas which could be changed and improved:

- provision of greater resources for CMP;
- communication and collaboration between CMP and the rest of Pathways;

- provision of greater, more detailed client information;
- the contract with DWP;
- links between CMP and external organisations.

Discussions about changes to resources focused on the money available to CMP managers, staffing and facilities. A commonly reported resource problem was that CMP providers did not currently have enough practitioners for CMP to run as smoothly as possible. CMP practitioners and clients were among those who noted that waiting times needed to be reduced, and practitioners and managers explained that this problem should be resolved with more practitioners. In addition, there were clients (in an area where practitioners were not all health professionals) who felt that CMP staff should be experienced in working with people with health problems, and clients (in an area where practitioners were health professionals) who suggested that Pathways advisers should also be health professionals. A need for improved staff retention was mentioned by some clients who had been upset when the practitioner they were working with left midway through their planned sessions. More clinical supervision, or provision to have external supervision, was also called for by some practitioners who were trained clinicians. Discussions about resources also focused on CMP facilities, with practitioners and clients wanting greater privacy, more space and less noise.

Although some Pathways advisers and CMP practitioners suggested that communication and collaboration between them had changed for the better since Pathways began, some saw room for further improvement. Some CMP practitioners and Pathways advisers felt that more training and advice for advisers, and practitioners meeting clients pre-referral to talk about the benefits of CMP, would help to improve further the number of clients choosing to engage with CMP, the appropriateness of referrals and ensure clients knew what to expect from CMP. In an area where CMP was sub-contracted and there was little collaborative working with practitioners, some advisers thought that observing CMP sessions, or inviting CMP practitioners to attend case conferences, would be effective methods for information sharing. It was suggested that enhanced collaboration, and better outcomes for clients, would result from Pathways and CMP staff sharing a client database. CMP practitioners and managers of one area felt the need for improved links with rest of Pathways, to ensure that people knew what they were doing next and received adequate support. This point can be linked with that made by a number of clients from several of the study areas, who wished that there had been more support to follow on from CMP. This seemed a particular concern among people who felt the impact made by CMP would be short-lived without continued support. Some clients envisaged returning to the CMP provider, on a one-off or regular basis, to discuss progress, be reminded of coping strategies, and try to meet any outstanding needs. Another suggestion was establishing client support groups that could continue to meet after CMP was completed.

The changes sought by CMP managers and practitioners regarding client information were to have more information from Pathways advisers with the referral (such as whether the client had experienced psychological therapy before), so that CMP assessments were more efficient and practitioners were more prepared when they met the client for the first time. One suggestion was for the client to have an opportunity to write about how they were feeling and for this to be included in the referral information. One practitioner (a clinician who worked on a one-to-one basis with CMP clients) wanted to redesign the assessment forms used throughout CMP sessions and remove the requirement to complete them during client sessions, because this practice was perceived as disruptive to the therapeutic environment.

Some managers and practitioners had a view that the contract with DWP had led to problems or constrained practice. For example, it was perceived that DWP had underestimated the mental health needs of the Pathways population and that this had left CMP providers ill prepared, particularly regarding staffing. Some practitioners and managers wanted the recording and measuring of 'soft' outcomes to be more comprehensive, to show Pathways advisers and clients the value of CMP and for these outcomes to be recognised by DWP in the overall performance targets for Pathways. One view was that there was too much uncertainty about the future of CMP created by short-term contracts and that the Government should support CMP programmes on a permanent basis, independent from Pathways contracts. Some CMP clients also suggested that it would be beneficial to promote CMP more widely and enable people to access the service as soon as they left work due to illness or disability.

At present, some practitioners felt that CMP was trying to plug a large gap in service provision and that more support was needed for people with mental health needs in particular. They also wanted to develop more links with external organisations or schemes (such as Improving Access to Psychological Therapy) so that they felt better able to refer or signpost people to available specialist services when clients needed more intensive support than CMP could offer.

6.4.2 Changes to the content and delivery format for CMP sessions

A number of suggestions were made by CMP staff and clients regarding the content and delivery format of CMP sessions. Suggestions focused on:

- the provision of individualised support;
- supporting people who are harder to help;
- the adequacy of support offered to meet people's needs;
- the kinds of support that should be offered or enhanced;
- the end of CMP contact.

A commonly held view among clients and some practitioners was that CMP should offer more tailor-made support for individuals. There were people who had not experienced one-to-one meetings with a CMP practitioner who thought that this would have been beneficial, and practitioners delivering one-to-one support who wished they could see more clients on an individual basis. Wanting support that focused more on individual circumstances and needs was also expressed regarding suggested changes to group sessions, by people who thought that groups should be small (for each individual to feel that their needs were heard and supported) or that groups could be streamed and cater for different groups of clients and their specific problems. Support groups for people with specific conditions were also suggested.

Two ideas were suggested in response to the perception that CMP could not, currently, cater for people with severe health conditions or people perceived as harder to help. One idea (offered by the manager of the provider delivering a programme of generic group sessions) was to offer a separate, more intensive programme for people with more complex and severe problems. Another suggestion made by a CMP client was that CMP practitioners should be given more resources to support people long-term. However, one CMP manager felt that CMP could not support those in greatest need and that it was for external healthcare services to provide quicker access to psychological or physical therapy and provide it long-term if necessary.

There were strong views among a number of clients, and some practitioners, that at present CMP support was insufficient even for people with fewer needs because of the infrequency or irregularity of support, the length of sessions or the length of the programme overall. In areas where clients waited a number of weeks between individual meetings, there were calls for shorter intervals between sessions, or for practitioners to be able to guarantee a regular slot for individuals, so that progress was maintained. One view was that one-to-one sessions should be longer, so that topics could be discussed in more depth and a deeper level of understanding could exist between practitioner and client. However, day-long group sessions in one area were considered to be too long because it was hard for clients to take in all the information presented. A number of clients and practitioners also said that they thought that CMP should offer support for longer, and this included people in areas where CMP ran for 12 weeks. There was a feeling among clients, particularly in the area where CMP ran for only four weeks, that there was not enough time to discuss all problems, to absorb information and advice, and to apply it confidently to everyday life.

In discussions about the content of CMP sessions a number of ideas were put forward for additional support that could be included, and ways in which the current support could be enhanced. Thus, some clients felt including the following in CMP would be beneficial: hypnotherapy, meditation or yoga, opportunities for work experience,⁸ vouchers for purchasing fruit and vegetables to promote healthy

⁸ It was unclear whether work experience opportunities were suggested as an option within CMP or as part of the Pathways programme in general.

eating, ongoing group activities (such as a walking group).⁹ Further to this, some clients and practitioners wanted CMP to place more emphasis on the following kinds of support or topics: support for people with physical problems (for example focus on managing pain and increasing mobility, offer people physiotherapy or passes for using a gym or swimming pool), building motivation for work, obesity and general well-being, advice about building and sustaining social networks outside CMP, relaxation techniques (by providing more practice time).

A number of clients felt that there could be improvements made to the end of CMP. Although some clients were happy with the way CMP ended, there were people who felt that they should have been given adequate notice of the end of the programme and the end of the relationship with practitioners. Another idea was that clients should be given course completion certificates, which could be shown to prospective employers.

6.5 Continuing barriers to work and support needs

As outlined in Section 6.2, at the time of the research interviews CMP clients were at various stages of readiness for work. Analysis of the client data showed that most people, (including some people who had made progress towards work since becoming ill or disabled, or since starting Pathways and CMP), had outstanding barriers to work and support needs. It is possible that some of the people who talked about barriers and support needs may have seen these barriers and needs addressed at a later stage, as they were still taking part in CMP and/or Pathways.

6.5.1 Barriers to work

The continuing barriers to work described by people in this research study related to the following:

- health status and perceptions of working with health problems;
- a lack of confidence or motivation;
- labour market barriers;
- the benefits system;
- personal circumstances.

For many people, ongoing poor health was still perceived as a significant barrier to working. Even people who felt that they had learned to manage conditions better were still concerned that their health would make it hard to commit to a paid job. This was especially the case for people without a confirmed diagnosis and who were uncertain about the prognosis and potential to manage their condition in work. One view was that the main barrier to working was not knowing what kinds of jobs would be suitable with ongoing physical problems.

⁹ This was suggested by a client who took part in a programme that did not offer a walking group.

Several people explained that the main reason they did not feel ready to take steps towards work was because they were nervous and lacked confidence. In addition, one client described lacking motivation to actually do the work-related activities he was considering, which he linked to an alcohol problem.

A range of labour market barriers were perceived by CMP clients. A commonly held view was that there was currently a lack of jobs, and thus competition for vacancies would be high. People doubted that, given their health history, they would be an employer's preferred candidates. Possessing a criminal conviction, being aged over 50 and speaking English poorly were also thought to put people at a disadvantage in the labour market. Not having a qualification for a chosen job could also be a barrier, especially where people did not have the funding required to undertake the necessary training.

In several different ways, the benefits system was perceived as obstructing some people's progress towards work. One person, who had lost entitlement to incapacity benefits and was appealing, found that the resulting feelings of stress had taken his attention away from focusing on work and the help offered through CMP. In addition, some people felt that the form of work that was suitable for them, given their ongoing health problems, (for example, part-time work, or gradually building up a business) was not affordable because they needed to work more hours to be better-off financially in work, or because benefits would stop being paid too soon.

Finally, other personal circumstances could also get in the way of focusing on work, such as where the client was moving home.

6.5.2 Support needs

Many of the support needs cited by people were to overcome the remaining barriers to work, discussed in Section 6.5.1. Some of these forms of support may have been available through Pathways, but people were not aware of these or did not perceive that they had been offered them. Thus, people described needing the following:

- long-term psychological support;
- continued help to manage anger;
- ongoing help to build confidence;
- intensive support throughout the stages of returning to work, including tailored advice about suitable jobs and opportunities for work experience or job trials;
- employment opportunities with flexible hours;
- information and advice about becoming self-employed
- financial support (for training and qualifications; to make work of a few hours worthwhile; to reimburse travel to a gym or swimming pool).

6.6 Summary

Chapter 6 has looked at study participants' views on the impact and performance of CMP. Although some providers were in the early stages of developing performance targets and measuring outcomes, views on performance so far were generally positive. Only one provider had a target to achieve job outcomes, but this had been imposed recently and there was no data on whether the target was being met or not.

The findings showed that CMP could make a difference to clients in the following ways:

- initiating progress towards work;
- enhancing progress towards work;
- improving well-being.

In particular, improved confidence and motivation, and learning to manage health conditions (and sometimes seeing symptoms improve) through CMP sessions seemed to help people to feel more ready for work, and sometimes to take steps towards work such as searching for jobs, taking up training or gaining paid employment. For people furthest from work, improvements in well-being could be achieved, which were regarded by practitioners as a first step in removing barriers to work.

However, there was also a view that CMP was not able to help all clients. This was evidenced by clients who said that participating in CMP had made no difference to them, or that the impacts made were limited or negative. It seems that personal circumstances (such as deteriorating health conditions) and aspects of delivery (for example, content seeming irrelevant, or staff leaving employment with the provider) could obstruct the potential for CMP to influence progress towards work or improvements in well-being.

Analysis of the data about the duration of CMP impacts suggests that some outcomes are typically longer-lasting (such as being able to control symptoms using practical techniques) because of service delivery methods (such as providing written information and advice that can be reviewed over time by clients). However, there were perceptions that where impacts were made during a short programme, or were not followed up with further support, these impacts could dissipate.

Overall, these findings suggested that CMP helped people to make progress towards work or positive changes in their lives, but that it did not often take people all the way to feeling ready for work. It was therefore important that follow-on support was available after CMP, to take the momentum gained through CMP into other activities.

Pathways advisers, CMP managers, practitioners and clients suggested improvements to operational and managerial matters (such as more practitioners, improved collaboration between Pathways and CMP staff, and more client

information at an earlier stage) and to the content and delivery of CMP sessions (such as providing more individualised support, more interventions targeted at physical conditions and provision of further support once CMP has ended).

Chapter 7 will reflect further on the following points:

- that CMP can help some people make progress towards work and it is helpful to understand CMP as one stage in a sequence of support that is required to achieve job outcomes;
- the aspects of delivery that impede client progress;
- that CMP impacts can dissipate if further support is not offered to people soon after CMP contact ends;
- people who find that CMP has made no difference and their outstanding needs.

7 Conclusions and discussion

Pathways providers were given a degree of autonomy in designing and delivering Condition Management Programmes (CMP)s. Between the four Pathways districts included in this study there was much variation in staffing practices and the content and format of interventions offered, and in experiences of in-house or sub-contracted delivery. This meant that CMP clients were not taking part in a programme that was replicated in design and delivery across districts, but were instead experiencing very different programmes. The task in writing this report has not been to identify which model for providing CMP works best, but to draw out lessons from key stakeholders' experiences of what works well in the design and implementation of CMP, and what could be improved, to inform future practice.

This chapter draws on the key themes that emerged from the study findings to discuss a number of implications for policy and practice regarding CMP. The findings and this discussion may be of use to policy makers and practitioners concerned with CMP delivery in Provider-led Pathways districts as well as districts where CMP is provided by Jobcentre Plus in partnership with the NHS. The key implications for policy and practice are presented using the following themes:

- the role of Pathways advisers in informing people about CMP and making referrals;
- staffing within CMP;
- what works well regarding the delivery and impact of CMP;
- reaching the end of CMP and providing ongoing support.

7.1 The role of Pathways advisers

The role of Pathways advisers in the effective operation of CMP emerged as a key theme in the study findings, particularly with regard to the following issues:

- informing people about CMP and making appropriate referrals;
- managing client expectations about the purpose of CMP.

The findings suggest that Pathways advisers have a key role to play in informing people about CMP and making appropriate referrals. There were signs that this role was not always performed well, particularly where numbers of referrals had been low and practitioners made complaints about some clients being referred inappropriately. Being able to engage clients with the idea of trying CMP, and making appropriate referrals, were perceived by CMP and Pathways staff as depending to a large extent on advisers' grasp of the main aims and potential benefits of CMP. Although progress towards better communication and collaboration between Pathways and CMP staff had been made in most of the study areas, it seems that further attempts to improve collaborative working would be beneficial. Sharing office space was extremely significant in staff working well together in these districts. In a previous study of CMP, CMP practitioners based in Jobcentre Plus offices also considered working in close proximity as advantageous for facilitating informal communication about clients and boosting referral rates (Barnes and Hudson, 2006). The findings suggest that the more that CMP practitioners collaborate with Pathways advisers, the deeper the latter's understanding of CMP and common health conditions could become, resulting in higher levels of appropriate referrals.

There was some evidence that Pathways advisers' heavy promotion of, and subsequent referral to, CMP was not always appropriate for clients and could result in clients choosing not to attend CMP sessions. It was certainly the case that some people felt that they had no choice about attending CMP because of the way the adviser had talked about it. Although not explicit in the data, it could be interpreted that pressure from performance targets to get clients engaged in a Pathways intervention or work-related activity were linked to advisers' enthusiastic promotion of CMP, and sometimes hindered their ability to make well-judged decisions. It could also be interpreted that not having enough time to get to know clients meant that advisers could not tell when clients (who were not keen about attending CMP) agreed to a CMP referral for the sake of pleasing the adviser. It was also evident in the study findings that client perceptions of being under pressure to return to work could sometimes be attributed to experiences of CMP as well as Pathways in general. This was particularly the case where CMP was run in-house (where clients' initial negative impressions of Pathways were transferred to CMP because they were run by the same organisation) and where clients felt they were a long way from being ready to enter the labour market.

Managing clients' expectations about what CMP might be able to achieve was another part of a Pathways Adviser's role which was perceived by CMP practitioners as poorly executed on occasions. Of course, there may be times when advisers stress that CMP helps people to **manage** rather than **treat** conditions, but clients do not take this information on board. However, having high expectations that cannot be met through CMP could leave clients feeling deflated, affect continued attendance and reduce the likelihood of CMP making a positive impact. The findings suggest that, given the potential gains for attendance and impact, it may be worth reviewing advisers' training and practice regarding CMP.

7.2 Staffing within CMP

There were two main findings regarding staffing within CMP that had implications for policy and practice:

- the importance of CMP practitioners being able to demonstrate expertise and empathy;
- problems resulting from a shortage of staff and staff turnover.

The qualifications and experience of CMP practitioners in the study areas varied from people with clinical backgrounds to people who had limited previous experience of working with people with health conditions. The findings were not conclusive about whether help received from clinicians or non-clinicians was more beneficial, as there were clients in each area who made positive remarks about the practitioners they met. However, what seemed important was that practitioners demonstrated some level of expertise or experience, so that people felt they could trust the information and advice they received. In particular, if advice touched on ways of improving or managing symptoms (for example, suggestions to gradually change the use of medication), people wanted assurances that practitioners knew what they were advising and had undergone some level of professional training. Mixed views about the need for clinically trained CMP practitioners were also apparent in previous research that looked at the provision of CMP in Jobcentre Plus-led Pathways (Barnes and Hudson, 2006). In that study, some views highlighted the knowledge and experience of clinicians as necessary, and some insisted that not all CMP staff roles required the skill sets of clinically trained professionals.

As well as trusting practitioners, finding practitioners empathetic and good listeners, and continuity in the staff seen, were important for clients in building rapport with practitioners (similar findings were reported in a study of client's experiences of CMP within Jobcentre Plus-led Pathways [Warrener *et al.*, 2009]). In turn, having a good rapport with practitioners was often linked to making improvements to well-being, or progress towards work. Thus, getting staffing right seems significant for achieving client outcomes. These findings may be helpful for CMP managers in deciding who to appoint to their staff. And, so that clients are not left uncertain or worried about the professional background of practitioners, it might also be helpful if practitioners explained to all new clients how they are adequately trained for their job.

At the time of the research interviews, some CMP providers were experiencing problems concerning staffing levels. One problem was that there were too few practitioners to meet client demand and waiting times had grown as a result. Another problem centred on staff turnover, meaning that some clients did not receive continuity of support. Again, there were implications for clients' ongoing engagement with the programme and for achieving positive outcomes, resulting from these two staffing issues. Not only do these findings suggest a need for more practitioners (which was planned by managers in most areas) but also improved staff retention. Although practitioners were generally content with the level of

support and supervision provided to them, there were some indications that practitioners with clinical backgrounds were not wholly satisfied with the amount of clinical supervision that was available. And although practitioners might have been attracted to take up employment in CMP because of its new and innovative status, the relatively low pay afforded to CMP practitioners might hinder staff retention over the long-term. If CMP managers are hoping to retain clinicians then they may need to offer more frequent clinical supervision and opportunities to practise their clinical skills elsewhere, and consider offering more competitive salaries.

7.3 What works well regarding the delivery and impact of CMP

This section discusses the following issues:

- the value of individually tailored support and social interaction through group sessions;
- the need for more specific interventions for people with physical health conditions;
- what works well in approaching the topic of work in CMP sessions;
- the importance of individual attitudes and a trusting relationship between clients and practitioners in making positive impacts through CMP;
- people who are not currently helped by CMP and ways in which aspects of delivery can hinder client progress;
- the role of CMP in clients' wider networks of support;
- the importance of ensuring the outcomes of Work Capability Assessments do not hinder clients' participation in CMP.

As explained in Chapter 2, not all clients were offered choice about the CMP interventions they took part in. The findings do not suggest one way or the other whether widening or restricting client choice is beneficial for clients. What is clear however is that some people do not benefit from provision that has general application, in group settings where participants share little in common. Furthermore, tailoring support to individual circumstances and needs was considered extremely valuable where it was experienced (and appointments were at regular intervals), was desired by people who did not experience it, and was well regarded by CMP practitioners as an effective method for resolving problems and helping people achieve positive outcomes. In an earlier study of CMP in Jobcentre Plus-led Pathways areas, practitioners stressed the importance of delivering a service that can be tailored to meet individual needs (Barnes and Hudson, 2006). Providing individually tailored support lends itself naturally to one-to-one meetings between practitioners and clients. However, it was apparent that similar kinds of individual support could be produced through sessions in small groups, where there was time to talk about each participant's problems and for

practitioners to offer specific advice. Other positive impressions of group sessions, such as improving social interaction and providing a sense of solidarity between members, strengthen the argument for the inclusion of group work in CMP.

The implication from these findings (and from previous research on CMP, Warrener *et al.*, 2009) is that offering people a choice of individual meetings and well facilitated, small group workshops might meet more people's needs for specific support and interaction with other people. Although one of the providers in this study offered this mix of specific support (through one-to-one contact) and group interaction (through a variety of workshops), very few of the clients interviewed for this study in this area had yet experienced both kinds of support. However, those who had experience of both, or who were aware of the range of support available, were less likely than people in other areas to say that the programme did not cater for their needs. It is possible, therefore, that in offering a range of individual and group support, more people who would have stopped attending CMP because they found it irrelevant or an uncomfortable environment, may choose to keep attending till the end of the programme, thus maximising opportunities to help people make progress towards work.

However, there are outstanding questions about how to help people who drop out of CMP because of poor or deteriorating health, and people who find that CMP does not cater adequately for physical health problems. The findings show that CMP can help people with physical conditions who also have feelings of anxiety or depression, and who lack confidence and motivation. However, it seems that improvements in managing chronic pain or improving mobility are harder to achieve and do not appear to be targeted in programmes where none of the interventions focus on providing support for physical conditions. CMP in Jobcentre Plus-led Pathways was also considered by clients to have concentrated largely on mental health and to have made little impact on physical problems (Warrener *et al.*, 2009). The findings from this study also suggest that (by design) CMP does not at present help people with deep-rooted or severe mental health problems. In all these cases it seems that people are more reliant on health care services delivering the necessary medical or surgical interventions, or long-term support from physiotherapists or psychologists, to break down barriers to work. However, views from staff and clients suggest that CMP could do more for people with physical ill health. Although the few people in this research study who had experience of pain management workshops or advice about physical exercises had not yet found that this help made a difference, there were staff and clients who thought this kind of help was essential and clients who had accessed support for physical conditions elsewhere and found it beneficial. Interventions that provide instruction or opportunities for improving physical fitness were also considered valuable by people with a range of health problems. Therefore, if CMP continues to aim to serve people with physical conditions as well as mental health problems, then the evidence suggests that providers may need to provide specific interventions for managing physical pain, increasing mobility and improving fitness.

As CMP sits within the Pathways to Work programme, discussions about work in CMP sessions were expected by clients to some extent. However, CMP practitioner and client experiences show that people could feel wary about talking about work and that feeling pressure to return to work as soon as possible sometimes had a negative effect on attendance. The findings suggest that client motivation to work again often determined whether people responded positively to work-oriented discussions. Thus, a useful approach seems to be for practitioners to assess clients' level of motivation and readiness for work and to judge on an individual basis when to talk about work, perhaps waiting for clients to initiate a discussion about future aspirations. In group workshops, approaches that appear to work well involve positioning work-focused discussions in later sessions (after rapport has been developed and as people begin to make personal progress), stressing that the programme is not trying to get people into work as quickly as possible, and emphasising that non-work outcomes are also important.

This study has shown that CMP can make appreciable differences to people's well-being and readiness for work in a variety of ways, most notably by improving confidence and motivation, and by helping people to self-manage health conditions and improve general health and fitness (impacts that were also prominent in other studies: Barnes and Hudson, 2006; Ford and Plowright, 2009; Warrener *et al.*, 2009). Moving into paid work seems a much less common **direct** outcome, though it could be argued that CMP helps people take necessary steps towards work and enhances the likelihood of returns to work at some stage in the future. These findings strengthen the argument that it is helpful to monitor and measure outcomes that show the 'distance travelled' or progress made, rather than solely whether people enter paid employment. Client attitude (to want to make life changes) and trusting relationships between clients and practitioners were considered by CMP practitioners and clients to be particularly important for achieving positive outcomes. And this emphasises again the significance of making appropriate referrals (i.e. referring people with mild to moderate health conditions, who want to make changes in their life) and of recruiting staff with excellent interpersonal skills and expertise in working with people with health problems.

CMP does not help all clients however. As indicated above, some health problems or personal situations may be so severe or complex that CMP is not equipped to provide what is necessary to remove their main barriers to work. Nevertheless, it might be assumed that it is possible to help people who feel that their progress is hampered by problems in the delivery of CMP. If providers are to maximise opportunities to help people make progress towards work, then it may be necessary to ensure that the programme is relevant to a wider group of clients (including people with physical conditions), that it is delivered efficiently, that there is continuity of support till the end of the programme, and that sufficient support follows on from CMP.

Any consideration of the value and impact of CMP could also usefully explore the role of CMP in clients' wider networks of support. This study and an earlier

study (Warrener *et al.*, 2009) have demonstrated that, for some people, CMP is an important source of information about conditions or methods for managing symptoms (as alternatives to just taking medication), particularly where this information has not been forthcoming through contact with health services. On the other hand, other sources of support can be more valuable to people where it is perceived as offering help that CMP does not, for example specialised support for specific health conditions. It seems likely, therefore, that those who reap the most benefit from CMP are people who feel they have little effective support from elsewhere.

There were some suggestions in this study that if people lost entitlement to Incapacity Benefit or Employment and Support Allowance while on CMP, then further sessions were suspended or clients were unsure whether they could continue on CMP, thus interrupting or halting client progress. It might be preferable therefore to adopt an approach, which was agreed for clients taking part in CMP in Jobcentre Plus-led Pathways districts (Warrener *et al.*, 2009), allowing any client who starts CMP to complete the programme, irrespective of their benefit status. It might also be helpful to instruct Pathways advisers to refrain from making referrals to CMP until the client has undergone the Work Capability Assessment and benefit status is certain.

7.4 Reaching the end of CMP and providing ongoing support

A number of sub-themes about the end of CMP and ongoing support emerged from the study findings and have implications for policy and practice. These sub-themes include:

- the need to signpost in advance the end of CMP;
- the need for further support after CMP and seamless handovers between CMP and Pathways;
- the importance of developing links between CMP, Pathways and external sources of client support.

There were indications in the data that some people who had enjoyed and benefited from CMP were disappointed when they reached the end of the programme. Continuing to meet with fellow participants seemed to be helping some people sustain positive outcomes from CMP, such as increased confidence, self-esteem and social interaction. However, reaching the end of appointments without perceiving any prior warning was upsetting where people felt they had built strong relationships with practitioners and that they were suddenly left unsupported. This demonstrates the importance for all practitioners to manage expectations at the outset about the level and duration of contact and to signpost the ending of contact.

There is also evidence in this study and previous research (Warrener *et al.*, 2009; Ford and Plowright, 2009) that people need further support after CMP, to ensure positive impacts are long-lasting and to help remove barriers that still persist after CMP. People often expressed disappointment that CMP had not lasted longer or led to support to take next steps. These findings suggest that CMP amounts to only one form of support in a whole sequence of provision that is needed before clients are ready for work. Thus, if impact dissipation is to be avoided and if ongoing needs are to be addressed, then it seems crucial that the end of CMP joins up neatly with Pathways. Some Pathways advisers found it helpful to ensure that a number of work-focused interviews remained after CMP so that there were planned opportunities to provide additional support. Three-way meetings between the client, CMP practitioner and Pathways adviser (to discuss progress so far and outstanding barriers and needs) were considered effective for making seamless handovers back to Pathways by those who had experienced them. Shared access to a client database may also aid collaborative working and continuity of support for clients. At the very least it seems that there is a need for clarification about whether CMP staff or Pathways advisers initiate discussions with clients about next steps after CMP.

There were also views that CMP does not deliver support over a long enough period to get to the root of some people's problems. In part this may be a reflection of the lack of flexibility within some CMP programmes to continue offering help to people whose needs outlast their allotted sessions. This finding may also indicate that some people may require long-term support through health care and other services.

It is worth noting that at the time of the research interviews providers were at an early stage in implementing Pathways and CMP, and in working collaboratively. There were intentions to develop more joined-up ways of working between Pathways and CMP staff, and with external health services and other organisations. In earlier research (Barnes and Hudson, 2006), CMP practitioners and managers were keen to develop links, particularly with job brokers, GPs and voluntary sector organisations, to identify appropriate further support for CMP clients, to liaise with about support plans for clients, or to provide work experience opportunities. The findings from this study suggest that more collaborative working would be of value to advisers (in tracking client progress through CMP), to CMP practitioners (in knowing how an adviser is working with a client, and where to refer people for more appropriate help if necessary), and to clients (in getting the support that they need where this is not provided through CMP).

It was not possible within this study to develop an understanding of CMP's role in helping people to stay in work, as data on this topic was very limited. Previous research on the provision of in-work support in Jobcentre Plus-led Pathways (Dixon and Warrener, 2008) shows that in-work support can be a significant influence on the ability to sustain work, particularly where people have histories of mental health problems, low self-confidence and uneven employment. However,

there were also indications that health problems in work could not always be tackled effectively and sometimes led to people leaving jobs. In this study of CMP, some CMP practitioners described how they hoped to be able to tackle health-related problems in work by offering specialist interventions such as ergonomic assessments or hands-on treatment. Therefore, it could be interpreted from this evidence, and that of earlier research, that there is potential for CMP to have a useful role in keeping people in work.

7.5 Concluding comments

This report has considered key stakeholders' experiences and views of CMP within Provider-led Pathways. The findings show that CMP can help to improve people's well-being and readiness for work, notably through building confidence and motivation, and equipping people to self-manage health conditions. However, there were also indications that some clients are not helped by CMP at present because the programme does not cater for their needs or because problems exist in aspects of delivery. The findings highlight the importance of the following aspects of delivery:

- ensuring Pathways advisers have a good understanding of the purpose and content of CMP;
- recruiting and retaining CMP practitioners with excellent interpersonal skills and experience of working with people with health problems;
- providing opportunities for both individual support and group interaction;
- offering specific support for physical health conditions;
- ensuring clients are well supported after contact with CMP ends;
- developing collaborative ways of working between Pathways and CMP staff and with external service providers.

In conclusion, the findings suggest that CMP is an essential part of Pathways, by helping people make progress nearer to job readiness.

Appendix A

Provider-led Pathways, study of the Condition Management Programme: Research methods

A.1 Recruiting participants

This study of the Condition Management Programme (CMP) was led by a research team at the Social Policy Research Unit (SPRU) at the University of York. The research comprised empirical work with staff and clients of Condition Management Programmes in four Provider-led Pathways districts, generating data from multiple perspectives and detailed insights into different roles and experiences.

The study was conducted in two main phases. The first phase comprised group and individual interviews with staff, which included Pathways advisers, CMP practitioners, and CMP managers (CMP managers within main Pathways providers and those within sub-contracted organisations, where applicable). The staff interviews and data extraction were conducted by a team of researchers at the National Centre for Social Research (NatCen). The second phase involved individual interviews with recent CMP attendees and was undertaken by researchers at SPRU.

The four study locations were chosen to ensure the following characteristics in the study sample:

- four different Pathways provider organisations;
- two providers who were delivering CMP in-house and two providers who had sub-contracted delivery;

- two providers who started delivering Pathways in the initial phase of the pilot in December 2007 and two who had commenced the programme five months later in April 2008;
- a geographical spread.

A.1.1 Staff of Pathways providers and CMP providers

Findings from an earlier study of the Jobcentre Plus and NHS-led Condition Management Programme (Barnes and Hudson, 2006) showed much diversity in the design and delivery of programmes in different locations. Given that Provider-led Pathways providers had relative freedom in designing their own Condition Management Programmes, it was expected that the implementation of programmes would again vary between districts. To help the research team to understand more about the models and operational arrangements being used for the programmes in the study areas, a scoping exercise was devised as a preliminary to the main fieldwork. This exercise was also designed to help the research team identify staff members to approach for interviews at a later stage.

The scoping exercise involved 20-30 minute telephone interviews with a Jobcentre Plus Third Party Provision Manager (TPPM) and a Pathways provider manager in each district. Contact with TPPMs and Pathways managers was facilitated by Department for Work and Pensions (DWP) colleagues. During the scoping interviews, informants were asked to provide details on the following topics:

- whether CMP was being delivered in-house or by a sub-contracted organisation;
- the main kinds of interventions offered and delivery locations;
- whether any performance targets had been imposed;
- staffing arrangements;
- level of contact between TPPM and CMP managers;
- the kinds of management information kept by providers;
- the size of caseloads, number of fail to attends and methods for recording client information.

The data were extracted into a proforma that was subsequently used as a basis for discussion between SPRU and NatCen about the design of topic guides for the main fieldwork with staff and about who should be approached for interview. Table A.1 shows the personnel who were identified through this exercise and contacted about participating in a research interview.

Table A.1 Pathways and CMP personnel to be approached for research interview

	Number of personnel across the four districts
CMP manager, Pathways provider	6
CMP manager, sub-contractor	3
CMP practitioner	14
Pathways advisers, Pathways provider	3-5 in each area

At this stage it became clear that where CMP was sub-contracted there would be value in interviewing not only the sub-contractor manager (who might be considered to have a similar role as an in-house CMP manager, in managing and supervising CMP practitioners) but also the manager at the Pathways provider responsible for monitoring the contract with the sub-contractor. The Pathways provider CMP manager was expected to have a slightly different role in managing a contract and its performance, rather than staff and the day-to-day running of the programme, and might also provide information about the design of CMP in that area and reasons for sub-contracting delivery.

When making arrangements for the staff interviews, contact was first re-established with the managers who had taken part in the scoping exercise. These managers facilitated contact with other staff at their organisations or with sub-contractors, to arrange convenient times and venues for interviews.

A.1.2 CMP clients

The study design included individual interviews with 36 people (nine in each of the four study locations) who had some experience of participating in CMP. Individual interviews were selected to give sufficient time for thorough exploration of individual experiences and views.

In the original study proposal, the research team expected to be able to recruit CMP clients using a database extract supplied by DWP listing everyone referred to CMP between November 2008 and January 2009. Using this information, the researchers hoped to recruit 36 people with diversity in primary health condition, sex, age and type of referral (either mandatory or voluntary). However, problems accessing data that referred only to CMP participants (and not also to people participating in Pathways who had no experience of CMP), meant that this plan had to be abandoned. Instead, the research team sought to recruit appropriate people using providers’ own records of attendees.

At this point researchers saw an opportunity to recruit people at different stages of progress through CMP. A decision was made to ask providers to supply a list of the 50 most recent CMP attendees, which was likely to include people attending for the first time, people returning for further sessions, and people attending their final meeting. The next step was for DWP colleagues to contact Pathways provider

managers to request their permission to help with the recruitment process and to name a member of staff with whom the researchers could liaise. Managers were assured that confidentiality would be secure through a number of measures:

- Providers were invited to handle an opt-out procedure, sending letters to potential participants and recording any responses that indicated an opt-out or opt-in to the study. This way the research team would only be given contact information (names, addresses and phone numbers) for people who had not opted out of the study during the opt-out period.
- Transfer of data would be completed securely by researchers travelling to provider premises to personally transfer information to an encrypted laptop.

After all the managers had consented, the research team collaborated with the key contact at each provider to establish the preferred ways of working. During negotiations, two providers decided that they would prefer the opt-out process to be handled by the research team because of time constraints. This meant that researchers collected from these two providers contact information for all of the 50 recent attendees, sent opt-out letters and recorded any replies. Where providers chose to manage the opt-out process themselves, the research team prepared an opt-out letter and reply slip for providers to use to minimise their workload (the opt-out letter and reply slip templates can be found in Appendix B).

Opt-out letters were sent to a total of 200 people in June 2009. During the two-week opt-out period 14 people notified either the Pathways provider or the research team that they did not want to take part in the research. Also during this time, five people got in touch to say they would like to be interviewed.

After the opt-out period had ended, a member of the research team visited provider premises to transfer data relating to people who had not communicated their intention to opt-out.

All of the providers supplied names, addresses and telephone numbers for potential study participants. Three of the four providers also provided information about primary health conditions, age and sex; one of these providers also indicated whether the CMP attendees had just started the programme, were midway through or had completed it. Following the opt-out period researchers were able to use this information to select and recruit people to the research study by telephone. The intention was to recruit a mix of ages and health conditions and a roughly equal balance between men and women. It was expected that variation in length of time on CMP would be found among the achieved group of research participants without sampling for it.

At the stage of telephone contact, a number of people declined to take part. Reasons given for not taking part were being too unwell, not recognising CMP as something they were aware of, not having started on the programme yet, having already given their views about the programme in another evaluation, being too busy making a benefit appeal, being on holiday during the fieldwork period, and

not wanting to take part. It was initially agreed with one person that they would not take part because it was not clear whether they had started on CMP or not. However, when this person later re-contacted the research team to clarify that they were on the programme and to say that they would like to be interviewed, an interview was set up. In addition, one interview was arranged to be conducted by telephone but the participant did not answer the phone at the arranged time or on subsequent attempts to make contact, so this person did not take part in the study.

In two areas, the target of recruiting nine participants was achieved. In one area however, it was only possible to recruit eight people in the time available, but the shortfall was made up in another area where ten interviews were achieved. Appointments for the face-to-face research interviews were arranged by telephone and confirmation letters were sent afterwards.

A.2 Conducting the research interviews and group discussions

This section describes how fieldwork was conducted and sets out the key elements of the research instruments used.

A.2.1 Staff of Pathways providers and CMP providers

The fieldwork with Pathways advisers, CMP practitioners and CMP managers took place between March and May 2009. All group and individual staff interviews were conducted face-to-face.

In total, 15 advisers from the four different Pathways contractors took part in four group discussions, each lasting for between 60 and 90 minutes. All group sessions took place on Pathways provider premises and were facilitated by one or two researchers.

Fourteen CMP practitioners took part in research interviews. Most were interviewed individually, but three practitioners of one sub-contractor were interviewed together. This occurred because there was not enough space for the practitioners to be interviewed separately, and all three were happy to take part in a shared interview. All of the practitioner interviews lasted approximately 90 minutes each.

In total, eight CMP manager interviews involving ten people were achieved, each lasting between 60 and 90 minutes. Two individual and one two-person interviews were conducted with in-house CMP managers. In areas where CMP was sub-contracted, one individual interview and one paired interview were conducted with Pathways provider CMP managers and three individual interviews were completed with sub-contractor managers. One sub-contractor manager also had a role working with clients as a frontline practitioner and was interviewed again about this role in a three-person interview with colleagues. To aid convenience, some of the manager interviews took place on the same day and at the same

venue as either the adviser group discussion or the individual interviews with CMP practitioners.

At the start of all of the group and individual interviews, researchers explained the purpose of the research, the topics to be explored, and that participants could withdraw from the research at any time. The confidentiality of the research was also discussed and the group participants were asked to be mindful of the need to keep confidential the views expressed by others during the session. All participants were asked if they consented to take part and all signed in agreement (see consent form in Appendix B). Permission to audio-record the group discussions and interviews was asked of all participants and all consented.

The main areas of enquiry for Pathways advisers were:

- their knowledge about CMP;
- their approaches to introducing CMP, client responses and take-up, and the process of making referrals to CMP;
- the level and nature of contact with clients and CMP staff after referral;
- their overall reflections on the delivery and impact of CMP.

The topics for discussion with CMP practitioners encompassed:

- experiences of receiving referrals including perceptions of the appropriateness of referrals;
- experiences of delivering CMP interventions and what happens at the end of the programme;
- (where sub-contracted) views on relationships with Pathways provider staff;
- the availability of staff support and the ways in which staff are supervised;
- their overall reflections on the delivery and impact of CMP.

CMP managers were asked about:

- the design of CMP delivery;
- the volume and appropriateness of referrals to CMP;
- the processes involved in monitoring performance and supporting staff;
- the importance and quality of relationships with Jobcentre Plus/DWP, with the Pathways provider or sub-contractor (as appropriate), and with other organisations;
- their overall reflections on the delivery and impact of CMP.

Separate topic guides were designed for the adviser group discussions, the interviews with CMP practitioners, interviews with Pathways provider CMP managers, and interviews with sub-contractor CMP managers, reflecting the differences in their respective roles and perspectives. These guides used headline

questions to mark each new line of questioning and suggested prompts to enable researchers to move through the interview in a responsive way, tailoring questions and prompts, and time spent, to the topics most salient to participants.

The topic guides were designed by the project's lead researchers at SPRU. Prior to commencement of fieldwork, a meeting was held between SPRU researchers and the research team at NatCen who would be conducting the staff fieldwork. This provided an opportunity for SPRU staff to explain the approach and topics explored and for NatCen researchers to ask questions. All of the researchers involved found this briefing session extremely helpful and an essential part of preparing for fieldwork.

After the first five interviews in one area, staff at NatCen and SPRU reviewed the transcripts and discussed whether any additions or alterations should be made to the topic guides. At this point a few extra prompts and probes were added to the topic guides to enhance capture of topics that might also occur in other areas but which had not been anticipated by the researchers. However, the main themes and questions were retained (the topic guides at Appendix B are the slightly amended guides used after the first five interviews had been completed).

A.2.2 CMP clients

Thirty-six CMP participants took part in qualitative interviews with researchers between June and August 2009. In the majority of cases, face-to-face interviews were conducted in private rooms in the offices of the Pathways provider. This option had been offered to minimise risk to the researchers in visiting people's homes and increase fieldwork efficiency. Many people had found this option convenient to them because they could combine the research interview with a pre-existing appointment with their Pathways adviser or plans to visit the Pathways office to use the computer facilities. People were also happy to attend a research interview at the Pathways office because they were familiar with visiting these premises. In contrast, however, six people chose to be interviewed at home because this was most convenient for them. A further four people were interviewed over the telephone. This occurred for a number of reasons, such as where the interviewee had been unable to keep their original appointment to meet the researcher face-to-face due to illness, and where this arrangement was better suited to the interviewee's availability. All those interviewed on the telephone were happy with this arrangement.

Another, separate topic guide was created for use with CMP participants (see Appendix B). The main areas of enquiry here were:

- their experiences of learning about CMP and their initial impressions;
- their experiences and views of attending CMP sessions;
- whether they had received any significant support from other sources since being referred to CMP;
- their reflections on any impacts that CMP had made.

Again, researchers explained the purpose for the research, the topics to be explored and the confidential nature of the interview. All participants signed a form to demonstrate their consent to take part. A money gift of £20 was given to participants as a token of thanks. People interviewed by telephone were asked to give verbal consent at the time of the interview, which was audio recorded. They were also sent consent forms and the money gift in the post and asked to return the signed consent form and receipt.¹⁰ Most interviews lasted for approximately 60 minutes and were recorded with participants' permission. One interview was not recorded because the participant did not feel comfortable with this arrangement. Instead, the interviewer made extensive contemporaneous notes.

A.3 Data analysis

Following the interviews and group discussions, all recordings were transcribed by professional transcribers.

The data held in transcripts or interviewer notes were analysed systematically and transparently using the **Framework** method of data management, originally developed by the National Centre for Social Research (Ritchie and Spencer, 1994). Data were extracted after each interview and group discussion by either the researcher who facilitated the interview or group discussion, or a member of their own research unit team.

A thematic framework was developed for classification and summary of the data from interviews according to the themes emerging. This approach meant that the analysis was grounded in respondents' own accounts, at the same time enabling analysis to address key policy interests and issues. The building of the charts enabled data interrogation and comparison both between cases, and within each case, and the researchers used the data to build descriptions and search for explanations.

Group discussions provide a good opportunity to explore similarities and differences in the experiences and views of participants. Rather than extract each group participant's data separately, summaries of discussion were entered into appropriate 'cells' in the charts to show explicitly where views were in agreement, were divergent, or were expressed by one person only.

Two members of the research team took responsibility for the analysis of the data and first draft of the report.

A.4 Characteristics of participating Pathways advisers, CMP managers and CMP practitioners

Table A.2 sets out the number of Pathways and CMP staff interviewed for this study and their roles. In two districts CMP was provided in-house and in the other two

¹⁰ Only one person did not return the consent form and receipt.

districts CMP was sub-contracted. From the scoping exercise, six CMP managers working for a Pathways provider were identified as potential participants. However, when recruiting managers for the interviews it became apparent that in one area there was another manager who had a valuable contribution to make to the research, and who was willing to take part. This meant that seven CMP managers working for Pathways providers were interviewed.

Table A.2 Pathways and CMP personnel interviewed

Role in CMP	Number of personnel interviewed
In-house provision	
CMP manager	4
CMP practitioner	8
Pathways adviser	8
Sub-contracted provision	
Pathways provider CMP manager	3
Sub-contractor CMP manager	3
CMP practitioner	6
Pathways adviser	7

A.4.1 Pathways advisers

Over the four study locations, 15 advisers took part in group interviews. All advisers had frontline responsibilities, had daily contact with Pathways clients and described their job title as ‘Pathways advisers’ or ‘employment advisers’. All except one adviser had been recruited by the Pathways provider to work specifically on the Pathways contract, though a number of these people had been recruited several months after the start of the programme. One adviser’s employment with the provider pre-dated the Pathways contract. There were advisers who had previously worked for similar employment service organisations and on ‘welfare to work’ programmes such as the New Deal. Other past job roles were in recruitment consultancy, sales, hospitality, property letting, various community services and projects (for example, for homeless people or people with drug and alcohol services), child protection, and the ambulance service.

A.4.2 CMP managers

The ten CMP managers interviewed occupied different roles depending on whether CMP was delivered in-house or was sub-contracted to one or two organisation(s). As Table A.3 shows, they also possessed varying qualifications and experience before taking up their current job.

Table A.3 Role and background of CMP managers

Role in CMP	Qualifications/background
In-house provision	
CMP manager	Clinical psychologist Occupational therapist Operational manager x2
Sub-contracted provision	
Pathways provider CMP manager	Registered nurse Operational manager x2
Sub-contractor CMP manager	Therapist Community mental health worker Registered nurse

Among the managers interviewed, three had clinical training and experience in psychology and psychological therapies, or community mental health work, with histories of working in hospitals, Social Services, mental health clinics and drug and alcohol rehabilitation centres. Furthermore, the manager who was an occupational therapist, who had extensive experience of working in the NHS and private sector, specialised in mental health. Two of the managers were registered nurses and had expertise in vocational rehabilitation or respiratory health problems, and experience of working as medical practitioners in the insurance industry or for pharmaceutical companies and Primary Care Trusts. In addition, two managers from one area where CMP was delivered in-house and another two managers who oversaw the CMP contract with sub-contractors had no clinical expertise and described themselves as general or operational managers. They shared backgrounds in working on various welfare to work schemes, and one of these managers had once worked in customer service management.

A.4.3 CMP practitioners

All of the 14 CMP practitioners interviewed had some kind of clinical training or qualification in psychology, counselling or complementary therapies. Table A.4 outlines the specialisms of the participating practitioners.

Table A.4 CMP practitioners' qualifications/professional background

Qualification/professional background	
Clinical psychologist/psychotherapist	4
Counsellor	4
Occupational therapist	1
Nurse	2
Physiotherapist	2
Complementary therapist	1
	14

The clinical psychologists/psychotherapists had previously worked in hospitals including high security psychiatric facilities, care homes and a prison. Hospital roles had also been performed by the physiotherapists, occupational therapist and complementary therapist. Those now working as counsellors often had varied work histories. Their past roles were in charity public relations management, as a Pathways adviser for the Pathways provider or Jobcentre Plus, as a Family Support Worker for the local authority Children's Services, in NHS and community work with people with mental health conditions, and in services for people with alcohol or drug problems. One counsellor had delivered cognitive behavioural therapy as part of an NHS-led Condition Management Programme during the original Pathways pilot. One of the nurses had extensive nursing experience in hospital and general practice and had undertaken occupational health roles with large employers. The other nurse was also interviewed regarding her role as manager and is included in Section A.4.2.

A.5 Characteristics of participating CMP clients

A.5.1 Age and sex of participants

The research team had hoped to recruit an even number of men and women and a split between age groups that reflected the population of incapacity benefits/ Employment and Support Allowance recipients.¹¹ However, recruitment was dependent on who had been the most recent CMP attendees in each area and it was by no means certain that these 50 people would include sufficient numbers in each age group or a wide range of health conditions. Also, as discussed in Section A.1, in one of the four research locations the researchers were given little information about potential study participants from the Pathways provider. Names were provided, which helped researchers to recruit a fairly even number of men and women, but it proved hard to identify younger people in particular. Together these limitations on recruitment meant that only four people in the youngest age range were interviewed. As Table A.5 shows, half of the 36 people who took part in this research study were aged between 31 and 49 with most of the remainder aged 50 or over.

¹¹ Of the population claiming Employment and Support Allowance at the time of the interviews, roughly 15 per cent are aged 18-24; 55 per cent are aged 25-49; 30 per cent are aged 50 and over (Employment and Support Allowance Caseload Quarterly Time Series, May 2009).

Table A.5 Age and sex of participants

Ages	Men	Women
18-29	1	3
30-49	9	9
50 plus	6	8
Totals	16	20

A.5.2 Stage reached in CMP

The stage reached by CMP participants through a series of sessions or contacts, at the time of the research interview, was of interest to the research team and variation in experience was sought. People who are still taking part in a programme can describe and explain their views and experiences at the time that it is happening and there are few problems with memory recall. They can also talk about their hopes and expectations for future participation. People who have completed a programme can adopt a more reflective perspective, thinking about their entire experience and summing up their overall views. They might also be able to comment on the duration of any impact after the programme has finished. Although it was not possible to recruit on the basis of length of time on CMP it was expected that variation would be found among the achieved group of research participants. Table A.6 shows the stages reached by those recruited to the study.

Table A.6 Stage reached in CMP at the time of the research interview

Stage reached in CMP	Participants
Assessment only	1
First session only	1
Mid-way through	15
Ended	
Programme finished	15
Ended part-way through	4
	36

At the time of the research interviews, 15 people had reached a midway point through the programme, having experienced a number of sessions and expecting more to follow. Some of those who expected to have more contact with their CMP practitioner did not have any appointments booked, but thought their practitioner would be in touch soon. In one area, where the CMP had a less defined end point, some people were expecting contact to continue indefinitely through participation in an exercise class or walking group. Nineteen people were no longer in contact with CMP staff, mostly because they had come to the end of the provision that had been offered to them. However, four people explained

that their participation in CMP had ended before the offer of more sessions had ceased. One of these people chose to stop participating because the programme was not suited to her needs. The remaining three people saw their contact end abruptly when the practitioner they were working with left employment with the CMP provider; although some explained that they were offered further sessions with another practitioner, they did not think it was worthwhile starting again with someone different. In addition, one person had only ever attended what might have been an assessment session and had decided at this point that CMP was not appropriate. Finally, one person had attended the first CMP session but no more since developing an illness.

A.5.3 Health

Researchers aimed to recruit a group of participants with a range of health conditions, though this was dependent on having this information at the recruitment stage and on there being variety in the 50 most recent attendees in the four locations. During the interviews, people told researchers about health complaints that had contributed to their decision-making in claiming incapacity benefits and that affected their capacity to work. Some of these health conditions continued to affect people’s day-to-day activities at the time of the interviews and were often influential in decisions not to take up work-related activities or paid work. Many people had multiple health problems and all those mentioned to the researchers are recorded in Table A.7.

Table A.7 Self-reported health conditions

	All self-reported conditions
Musculoskeletal	12
Mental health	27
Cardiovascular	0
Other	20

Some musculoskeletal conditions had appeared gradually and others were the result of road traffic accidents. Arthritis, spinal conditions and problems with other joints such as knees and feet were among conditions reported. A variety of anxiety and depressive illnesses, some of which had affected sufferers for a number of years and had resulted in breakdowns, were identified as main and secondary health conditions. A number of people said that stress, anxiety or depression had been caused by problems in the workplace, through loss of a job, relationship or love one, or through coping with another health problem. No one attributed their current incapacity for work to having a cardiovascular condition. Among other conditions people talked about were cancer, asthma, diabetes, thyroid problems, chronic fatigue syndromes, diseases affecting the digestive system, conditions affecting the lungs, brain injury, hearing difficulties, a peptic ulcer, alcoholism, a hernia and infectious diseases.

A.5.4 Finances and employment

Study participants were asked about their current and past status regarding benefits and employment to understand their movements onto incapacity benefits (and eligibility for Pathways) and any subsequent movements into paid work, voluntary work, education or training.

Prior to entering a claim for Incapacity Benefit, or Income Support (on the grounds of incapacity), almost half of the people who took part in this research study had been in paid employment, or receiving sick pay from their employer. Another subgroup had been out of work and either received a different benefit (Jobseeker's Allowance or Income Support as a lone parent), or had chosen to support themselves financially through personal savings or family financial assistance. One person had been in full-time education prior to becoming ill and claiming benefits. The remainder of the group explained that they had been receiving incapacity benefits for a number of years because of long-term health problems. It was not clear how these people (who were not new claimants of incapacity benefits) had become eligible for Pathways, but it seems that at least some people had voluntarily sought to join the programme after contact with a Jobcentre Plus adviser.

At the time of the research interviews, one person had been offered paid employment and was waiting for the job to start. Another person appeared to be working a few hours a week on a permitted work basis. In addition, one person said their job had been kept open by their employer and they hoped to return when their health improved. The remainder of the study participants were not working, did not have a job and most continued their claim for incapacity benefits. A number of the group had lost entitlement to incapacity benefits and were appealing against this decision. Of those not in paid work, some were taking steps which might aid their return to employment, such as undertaking educational and training courses or voluntary work. Some people said they were actively seeking work or had applied for jobs recently. Furthermore, a small number of people had intentions to start training or voluntary work in the short-term and had started making arrangements or applications as necessary.

There was no systematic collection of data concerning income sources in the research interviews, but some people did talk about other household income beyond incapacity benefits. In these cases people talked about receiving other benefits such as Disability Living Allowance, Housing Benefit, Child Benefit, or income-replacement benefits claimed by a partner, or their partner's earnings from work. One person said they had been in particular financial difficulty recently and a decision on their application to the Social Fund was pending.

Appendix B

Research instruments

B.1 Opt out letter



Heslington, York, YO10 5DD

KN/SP
Name and address

Telephone: (01904) 321950
 Fax: (01904) 321953
 Website: www.york.ac.uk/inst/spru

E-mail: rds2@york.ac.uk

5 June 2009

Dear [*Client's name*]

I am a researcher at the Social Policy Research Unit and I am writing to ask for your help with some important research on the Condition Management Programme. I am getting in touch with you because I understand that you have recently had contact with the Condition Management Programme in your area run by [*CMP provider name*]. The research we are doing is funded by the Department for Work and Pensions and will be carried out by a team of researchers here at the Social Policy Research Unit, which is an independent research organisation based at the University of York. We have been helped by [*Pathways provider name*] who are passing this letter to you and a number of other people in your area on our behalf.

The purpose of the research is to find out about people's experiences of the Condition Management Programme. In particular, we would like to know about people's reasons for taking part in the programme, what they think of the help offered and whether it has made any difference to them. We are keen to hear from people at various stages of the programme, so it will not matter if you have only had one meeting with Condition Management Programme staff or have now finished all the sessions. I have enclosed an information sheet about the research study and I hope that you find it useful.

In a few weeks a researcher from the Social Policy Research Unit may get in touch with you by telephone to tell you more about the research, answer any questions that you have and ask if you would be willing to take part in an interview. Please be assured that taking part is voluntary and will not affect any benefit you receive or any dealings you have with any government department or agency.

If you agree to be interviewed, the researcher will discuss a convenient time and place to meet, and any requirements you may have which will make it easier for you to take part. The interview is expected to last around 60 minutes. Anything you discuss with the researchers will be kept confidential in accordance with the Data Protection Act, which means that we will not share what you have told us with staff at [*Pathways provider and/or CMP provider*]. Everyone who is interviewed will be given £20 as a small token of thanks for their help.

Continued/...

.../2

I hope that if contacted by a researcher you do decide to take part in the study. If you do not wish to take part please could you let [*Pathways provider*] know by [date]. [*Pathways provider*] is helping us by keeping a record of people who have said they do not wish to take part. You can either fill in the attached form and return it in the pre-paid envelope, or you can let staff at [*Pathways provider*] know by telephone (*Provider phone number*), or by email (*Provider email address*). If you would like to talk to someone about this research, please do not hesitate to get in contact with me by telephone (01904 321951) or by email (rds2@york.ac.uk).

I hope you will be interested in taking part in this important research.

Yours sincerely

Roy Sainsbury

Research Team Leader

Enc.

B.2 Opt out reply slip



**Research study on the
Condition Management Programme**

Reply slip

Please only return this slip if you **do not** wish to take part in the research.

Name: _____

Signature: _____

Date: _____

Please return using the enclosed pre-paid envelope to:

[Provider name]

[Provider address]

B.3 Consent form



Research study on the Condition Management Programme within Provider-led Pathways

Consent Form

I have received the information sheet and understand the purpose of the research and what it involves. Yes No

I understand that the information I give to the researchers will be treated in strict confidence according to the Data Protection Act. Yes No

I understand that the research report will include my views along with the views of other people, but I will not be identified. Yes No

I understand that I can withdraw from the research at any time without giving a reason. Yes No

I agree to take part in an interview with a researcher. Yes No

Name _____

Signature _____

Date _____

B.4 Pathways provider manager topic guide



Provider-led Pathways CMP study Topic Guide: Pathways provider, CMP manager

Interviewer's introduction

- Explain that this research is funded by the Department for Work and Pensions, and is one part of their overall evaluation of Provider Led Pathways to Work.
- NatCen is an independent research organisation.
- This interview is part of a study investigating how the Condition Management Programme within Provider-led Pathways is being delivered and experienced. Researchers will be meeting with a number of CMP practitioners, managerial staff from CMP sub-contractors and Pathways providers, PLP advisers, and CMP clients from four of the new Provider-led districts. Interviews with clients will be conducted by the Social Policy Research Unit later this year.
- Our discussion today will concentrate on:
 - the design of CMP delivery;
 - the volume and appropriateness of referrals to CMP;
 - monitoring performance and the quality of working relationships (*in-house or with sub-contractor staff*);
 - relationships with Jobcentre Plus/DWP and other organisations;
 - your overall reflections on the delivery and impact of CMP so far.
- The discussion will take around an hour.
- Ask for permission to use recorder. Explain that recordings will be typed up professionally and seen only by the research team.
- Explain confidentiality and how material will be used – a report for DWP in which their views are included, but they will be anonymous.
- Taking part is completely voluntary.
- Check informed consent. Ask them to sign the consent form.

If asked what we mean by 'complying with the Data Protection Act' explain that we will:

- *keep all data in a secure environment;*
 - *allow only members of the research team (including administrators and transcribers) access to the data;*
 - *keep the data only as long as is necessary for the purposes of the research and then destroy it.*
-

1. Background information

Can you start by telling me about yourself and your role?

- Qualifications, experience (including length of time employed by organisation and role(s) held)
- What does your current role involve?
 - o PROMPT: any role in supporting Pathways advisers?
- Training for role: at outset, ongoing development
 - o PROMPT: Any Disability Equality Duty training?

How would you describe the Condition Management Programme – for example to a journalist or group of sixth formers?

2. Designing CMP delivery

Go to either 2a or 2b

2a. For providers who deliver CMP in-house:

What are you contracted to deliver regarding CMP?

- Specific kinds of interventions
- Can you explain how Department of Health clinical governance standards fit in to your contract?
 - o What does this mean in practice for you?
- Are there any targets in the contract? e.g. starts, completions, job outcomes

How is CMP organised?

- Locations and premises:
 - o Number of delivery sites
 - o Adequacy of premises for client/staff needs
- Staffing:
 - o Number of staff and their roles
 - o Is the number of staff as expected?
 - o Staff qualifications, experience
 - o Appraisal and development
 - o Any problems in recruitment or retention, improvement activity
 - o Training: at outset, ongoing development

- Service delivery:
 - Kinds of interventions offered
 - Any condition-specific provision
- Any changes in the structure of delivery over time? Why?

What/who influenced the design of your provision?

- Staff professional backgrounds; knowledge of clinical standards
- The delivery of CMP in JCP Pathways

2b. For providers who have sub-contracted CMP:

What are you contracted to deliver regarding CMP?

- Specific kinds of interventions
- Can you explain how Department of Health clinical governance standards fit in to your contract?
 - What does this mean in practice for you?
- Are there any targets in the contract? e.g. starts, completions, job outcomes
- What targets have you set the sub-contractor for delivering CMP?
- What are the funding arrangements with the sub-contractor? (E.g. paid per referral, per outcome)

NOTE TO NATCEN – TWO QUESTIONS DELETED HERE

What does CMP include?

- Kinds of interventions offered
- Any condition-specific provision
- Any changes in the structure of delivery over time? Why?
- What influence did/do you have in the sub-contractor's design of CMP?

3. Referrals to CMP

What is the proportion of the Pathways caseload that is being referred to CMP?

- Proportion who are mandatory Pathways clients or voluntary Pathways clients
- Do caseload sizes match with expectations
- Are caseloads manageable?
- What happens if caseloads reach maximum capacity? (e.g. waiting lists, referring people back to main provider, prioritising some clients)

What are your views about the appropriateness of referrals?

- Any problems regarding inappropriate referrals?

4. Monitoring performance and working relationships

Go to either 4a or 4b

4a. For providers who deliver CMP in-house:

How is CMP performance monitored?

- Do you have any in-house targets? [NOTE TO NATCEN – IF YES ASK WHAT THEY ARE AND FOLLOW UP WITH NEXT MAIN QUESTION]
- Any management information collected (e.g. starts, completions, referrals to other provision, client characteristics)?
- How is client progress assessed?
- Use of DWP Quality Framework and Self Assessment
- How is adherence to Department of Health clinical governance standards monitored?

[NOTE TO NATCEN – This may have been answered in 2a above]

- Attending review meetings with other Pathways managers; with JCP/DWP
 - Attending Provider Engagement Meetings

(ASK NEXT QUESTION IF APPROPRIATE)

How is CMP currently performing compared with (in-house) targets?

- Are the targets achievable?
- What currently helps/hinders the achievement of these targets?
- Any 'cultural clashes' between clinical interests and business interests?
- What would help to improve performance?
 - What improvement activity has been implemented?

In what ways are CMP staff supervised?

- Formal methods (e.g. performance reviews) and/or informal methods (e.g. conversations with line manager)
 - Probe for any clinical supervision
- Does this work well? Any suggestions for changes

In what ways are CMP staff supported?

- Formal methods (e.g. case conferences) and/or informal methods (e.g. conversations with colleagues)
- Contact with other provider staff and level of involvement with the rest of the Pathways programme
- Does this work well? Any suggestions for changes

4b. For providers who have sub-contracted CMP:

What contact do you and your advisers have with staff at the CMP sub-contractor?

- Who with?
- Purposes of contact (e.g. monitoring performance; financial arrangements; sharing information)
- How often?
- Usefulness of contact

How do you monitor the sub-contractor's performance?

- Formal methods (e.g. management information collected, client assessments, review meetings/Provider Engagement Meetings)
- Informal methods (e.g. weekly phone conversation)
- Use of DWP Quality Framework and Self Assessment
- How is adherence to Department of Health clinical governance standards monitored?

How is the CMP provider currently performing compared with YOUR targets?

- Are the targets achievable?
- What currently helps/hinders the achievement of these targets?
- What would help to improve performance?

What are your views about your relationships with sub-contractor staff?

- What helps/hinders these relationships?
- Any 'cultural clashes' between clinical interests and business interests?
- How could relationships be improved?

5. Relationships with Jobcentre Plus/DWP and other organisations

Do you have any contact with Jobcentre Plus staff or DWP contract managers regarding CMP? (for example Provider Engagement Meetings)

- Purpose (e.g. monitoring the provider's use of CMP)
- Frequency of contact
- Outcomes (e.g. any changes in use or delivery)

Do you have any contact with other organisations regarding CMP?

- E.g. NHS; IAPT; other private/voluntary organisations offering occupational health services; organisations offering other employment services
- Purpose (e.g. referring/signposting clients; exchanging ideas)
- Frequency of contact
- Outcomes and usefulness
- Views on quality and adequacy of available service provision; any problems or gaps

6. Overall reflections

What helps people attend CMP and engage with the support offered?

What hinders attendance and engagement?

What kinds of impact does CMP make on people?

- Changes in health
- Changes in well-being
- Changes in readiness for work
- Changes in ability to sustain work
- Any particular kinds of people who benefit most?
 - Any differences in terms of client characteristics (see separate list)?
- Any particular interventions that are key to achieving these impacts?
- Use of management information / customer feedback in assessing impact?

Do you have any other views about what works well in the organisation and delivery of CMP?

Is there anything that is not working well?

- People who do not benefit from participation in CMP
 - Any differences in terms of client characteristics (see separate list)?
- Interventions that are making little impact
- Problems with delivery or relationships
- Gaps in service provision

Are there any changes that you would you like to make to CMP?

Is CMP a necessary component of Pathways?

Thank you very much.

Check they are happy for their views to be included in our work.

B.5 Sub-contractor manager topic guide



Provider-led Pathways CMP study Topic Guide: Sub-contractor, CMP manager

Interviewer's introduction

- Explain that this research is funded by the Department for Work and Pensions, and is one part of their overall evaluation of Provider Led Pathways to Work.
- NatCen is an independent research organisation.
- This interview is part of a study investigating how the Condition Management Programme within Provider-led Pathways is being delivered and experienced. Researchers will be meeting with a number of CMP practitioners, managerial staff from CMP sub-contractors and Pathways providers, PLP advisers, and CMP clients from four of the new Provider-led districts. Interviews with clients will be conducted by the Social Policy Research Unit later this year.
- Our discussion today will concentrate on:
 - the design of CMP delivery;
 - the volume and appropriateness of referrals received;
 - the processes involved in monitoring performance and supporting staff;
 - relationships with Pathways provider staff;
 - any relationships with other organisations;
 - your overall reflections on the delivery and impact of CMP so far.
- The discussion will take around an hour.
- Ask for permission to use recorder. Explain that recordings will be typed up professionally and seen only by the research team.
- Explain confidentiality and how material will be used – a report for DWP in which their views are included, but they will be anonymous.
- Taking part is completely voluntary.
- Check informed consent. Ask them to sign the consent form.

If asked what we mean by 'complying with the Data Protection Act' explain that we will:

- *keep all data in a secure environment;*
 - *allow only members of the research team (including administrators and transcribers) access to the data;*
 - *keep the data only as long as is necessary for the purposes of the research and then destroy it.*
-

1. Background information

Can you start by telling me about yourself and your current role?

- Qualifications, experience (including length of time employed by organisation and role(s) held)
- What does your current role involve?
- Training for role: at outset, ongoing development
 - PROMPT: Any Disability Equality Duty training?

How would you describe the Condition Management Programme – for example to a journalist or group of sixth formers?

- Organisational background:
 - o Experience of delivering similar, occupational health services
 - o Size of organisation, location(s)

2. Designing CMP delivery

What are you contracted to deliver regarding CMP?

- Specific kinds of interventions
- Can you explain how Department of Health clinical governance standards fit in to your contract?
 - o What does this mean in practice for you?
- Main targets set by the provider organisation: e.g. starts, completions, job outcomes
- How are you funded by the Pathways provider? (E.g. per referral, per outcome achieved)

How is CMP organised?

- Locations and premises:
 - o Number of delivery sites
 - o Adequacy of premises for client/staff needs
- Staffing:
 - o Number of staff and their roles
 - o Is the number of staff as expected?
 - o Staff qualifications, experience
 - o Appraisal and development
 - o Any problems in recruitment or retention, improvement activity
 - o Training: at outset, ongoing development

- Service delivery:
 - Kinds of interventions offered
 - Any condition-specific provision
- Any elements of CMP sub-contracted to other organisations?
- Any changes in the structure of delivery over time? Why?

What/who influenced the design of your provision?

- Staff professional backgrounds; knowledge of clinical standards
- The delivery of CMP in JCP Pathways
- Pathways provider

3. Referrals to CMP

How many Pathways clients have been referred to CMP?

- Proportion who are mandatory Pathways clients or voluntary Pathways clients
- Do caseload sizes match with expectations
- Are caseloads manageable?
- What happens if caseloads reach maximum capacity? (e.g. waiting lists, referring people back to main provider, prioritising some clients)

What are your views about the appropriateness of referrals?

- Any problems regarding inappropriate referrals?

4. Monitoring performance and supporting staff

How is CMP performance monitored in-house?

- Any management information collected (e.g. starts, completions, referrals to other provision, client characteristics)?
- How is client progress assessed?
- Use of DWP Quality Framework and Self Assessment
- How is adherence to Department of Health clinical governance standards monitored?

How is CMP currently performing compared with targets/expectations set by the provider?

- Are the targets achievable?
- What currently helps/hinders the achievement of these targets?

- Any 'cultural clashes' between clinical interests and business interests?
- What would help to improve performance?

In what ways are CMP staff supervised?

- Formal methods (e.g. performance reviews) and/or informal methods (e.g. conversations with line manager)
 - o Probe for any clinical supervision
- Does this work well? Any suggestions for changes

In what ways are CMP staff supported?

- Formal methods (e.g. case conferences) and/or informal methods (e.g. conversations with colleagues)
- Contact with other provider staff and level of involvement with the rest of the Pathways programme
- Does this work well? Any suggestions for changes

5. Working relationships with the Pathways provider

What contact do you and CMP practitioners have with staff at the Pathways provider?

- Who with?
- Purposes of contact (e.g. monitoring performance; financial arrangements; sharing information)
- How often?
- Outcomes (e.g. any changes in delivery)

What are your views about your relationship with the Pathways provider?

- What helps/hinders the relationship?
- How could the relationship be improved?

6. Working relationships with other organisations

Do you have any contact with other organisations regarding CMP?

- Any sub-contractors for elements of CMP provision
- Any links with other organisations: Jobcentre Plus/DWP; NHS; IAPT; other private/voluntary organisations offering occupational health services; organisations offering other employment services
- Purpose (e.g. referring/signposting clients; exchanging ideas)

- Frequency of contact
- Outcomes and usefulness
- Views on quality and adequacy of available service provision; any problems or gaps

7. Overall reflections

**What helps people attend CMP and engage with the support offered?
What hinders attendance and engagement?**

What kinds of impact does CMP make?

- Changes in health
- Changes in well-being
- Changes in readiness for work
- Any particular kinds of people who benefit most?
 - Any differences in terms of client characteristics (see separate list)?
- Any particular interventions that are key to achieving these impacts?
- Use of management information/customer feedback in assessing impact?

Do you have any other views about what works well in the organisation and delivery of CMP?

Is there anything that is not working well?

- People who do not benefit from participation in CMP
 - Any differences in terms of client characteristics (see separate list)?
- Interventions that are making little impact
- Problems with delivery or relationships
- Gaps in service provision

Are there any changes that you would you like to make to CMP?

Thank you very much.

Check they are happy for their views to be included in our work.

B.6 Pathways Adviser topic guide



Provider-led Pathways CMP study Topic Guide: PLP advisers

Facilitator's introduction

- Explain that this research is funded by the Department for Work and Pensions, and is one part of their overall evaluation of Provider Led Pathways to Work.
- NatCen is an independent research organisation.
- This group interview is part of a study investigating how the Condition Management Programme within Provider Led Pathways is being delivered and experienced. Researchers will be meeting with a number of CMP practitioners, managerial staff from CMP sub-contractors and Pathways providers, PLP advisers and CMP clients from four of the new Provider Led districts. Interviews with clients will be conducted by the Social Policy Research Unit later this year.
- Our discussion today will concentrate on:
 - client profiles and take up of CMP;
 - adviser knowledge about CMP;
 - introducing CMP, client responses and making referrals;
 - contact with clients and CMP staff after referral;
 - your overall reflections on the delivery and impact of CMP.
- The discussion will take around 60-90 minutes.
- Ask for permission to use recorder. Explain that recordings will be typed up professionally and seen only by the research team.
- Explain confidentiality and how material will be used – a report for DWP in which their views are included, but they will be anonymous.
- Taking part is completely voluntary.
- Check informed consent. Ask them to sign the consent form.

If asked what we mean by 'complying with the Data Protection Act' explain that we will:

- *keep all data in a secure environment;*
 - *allow only members of the research team (including administrators and transcribers) access to the data;*
 - *keep the data only as long as is necessary for the purposes of the research and then destroy it.*
-

N.B. Questions marked with a star are priority areas of enquiry.

1. Brief introductions and background information

For each participant:

- Personal background
- Current and previous roles with provider organisation, including whether been with PLP since it began

2. Client profile

What are the characteristics of the clients in your caseload?

- Size of individual caseloads (and changes since contract started)
- Proportion of caseload referred to CMP
 - proportion of mandatory Pathways clients or voluntary Pathways clients
- (Re the whole caseload) Impression of readiness for work; range of health conditions

3. Knowledge of CMP

★ What do you know about CMP?

- Purpose(s)
- Content: kinds of interventions available
- Duration
- Format of delivery
- Views about adequacy of CMP knowledge and confidence in making referrals

★ How have you learned about CMP?

- Information supplied by CMP practitioners/sub-contractor staff
- Information from managers
- By referring clients and getting feedback

4. Introducing CMP and referring clients

★ Which clients would you tell about CMP?

- If not all clients, why?
- Do you receive the Work Focused Health Related Assessment (WFHRA)? Or conduct any other assessment/screening tool re appropriateness for CMP?

- o If so, does this inform your decision around referrals to CMP?
- o If so, how?
- When would you introduce CMP?
- What do you tell clients about CMP:
 - o when introducing it for the first time?
 - o when thinking about referring a client?
- Any changes in practice over time
- ★ **How do clients respond to hearing about CMP?**
- Any particular expectations about services offered, or how interventions will help them
- Why don't people want to attend CMP?
- ★ **What are the characteristics of the clients who decide to take up CMP?**
- i.e. age, health conditions, readiness for work
- Timing of referrals to CMP, in relation to client circumstances, participation in Pathways and other activities

How do you make a referral to CMP?

- Referral methods (e.g. phone call, paper/electronic form)
- Client information given

5. Contact with clients and CMP staff after referral

★ **Do you usually maintain contact with clients during their involvement with CMP?**

- Frequency of contact
- Purpose(s)
- Usefulness

★ **Do you usually have any contact with CMP practitioners after referral?**

- Frequency of contact
- Purpose(s)
- Usefulness

What happens if clients fail to attend CMP meetings?

- Involvement in attempts to (re-)engage them
- Numbers of people who are referred and never attend

- Numbers of people who attend at least once but miss some/all other sessions
- Perceived reasons for non-attendance

What happens when CMP modules/sessions have been completed?

- Are clients referred back - in all cases?
 - Any information fed back about client progress
- Are clients referred/signposted to other sources of support (internal or external) by CMP staff?
 - What kinds of support/which providers?
 - How often would this happen, in what circumstances?

Where sub-contracted:

What are your views about your relationships with sub-contracted CMP staff?

- What helps/hinders relationships?
- How could relationships be improved?

6. Views about impacts and overall reflections

- ★ **What helps people attend CMP and engage with the support offered?**
- ★ **What hinders attendance and engagement?**
- ★ **What kinds of impact does CMP make on people?**
 - Changes in health
 - Changes in well-being
 - Changes in readiness for work
 - Any particular kinds of people who benefit most?
 - Any differences in terms of client characteristics (see separate list)?
 - Any particular interventions that are key to achieving these impacts?
- ★ **Do you have any other views about what works well in the delivery of CMP?**
- ★ **Is there anything that is not working well?**
 - People who do not benefit from participation in CMP
 - Any differences in terms of client characteristics (see separate list)?
 - Interventions that are making little impact
 - Problems with delivery or relationships

- Gaps in service provision
- ★ Are there any ways in which CMP could be improved?
- ★ Is CMP a necessary component of Pathways?

Thank you very much.

Check they are happy for their views to be included in our work.

B.7 CMP Practitioner topic guide



Provider-led Pathways CMP study Topic Guide: CMP practitioners (in-house or sub-contracted)

Interviewer's introduction

- Explain that this research is funded by the Department for Work and Pensions, and is one part of their overall evaluation of Provider-led Pathways to Work.
- NatCen is an independent research organisation.
- This interview is part of a study investigating how the Condition Management Programme within Provider-led Pathways is being delivered and experienced. Researchers will be meeting with a number of CMP practitioners, managerial staff from CMP sub-contractors and Pathways providers, PLP advisers, and CMP clients from four of the new Provider-led districts. Interviews with clients will be conducted by the Social Policy Research Unit later this year.
- Our discussion today will concentrate on:
 - receiving referrals;
 - experiences of delivering CMP interventions;
 - what happens when CMP ends;
 - (*where sub-contracted*) views on relationships with Pathways provider staff;
 - the availability of staff support and the ways in which staff are supervised;
 - your overall reflections on the delivery and impact of CMP so far.
- The discussion will take around 90 minutes.
- Ask for permission to use recorder. Explain that recordings will be typed up professionally and seen only by the research team.
- Explain confidentiality and how material will be used – a report for DWP in which their views are included, but they will be anonymous.
- Taking part is completely voluntary.
- Check informed consent. Ask them to sign the consent form.

If asked what we mean by 'complying with the Data Protection Act' explain that we will:

- *keep all data in a secure environment;*
 - *allow only members of the research team (including administrators and transcribers) access to the data;*
 - *keep the data only as long as is necessary for the purposes of the research and then destroy it.*
-

1. Background information

Can you start by telling me about yourself and your current role?

- Qualifications, experience (including length of time employed by organisation and role(s) held)
- What does your current role involve?
 - PROMPT: any role in supporting Pathways advisers?
- Training for role: at outset, ongoing development
 - PROMPT: Any Disability Equality Duty training?

How would you describe the Condition Management Programme – for example to a journalist or group of sixth formers?

- In practice do you explain CMP to new clients?
 - Do you say anything different to what you have just said?
 - Do you think they fully understand what CMP is? And isn't?
- If not, why do you think this?

2. Referrals to CMP

How are referrals to CMP made?

- Referral routes: all from main Pathways provider, or can people come to CMP from GPs, direct from JCP, from others?
- Referral methods (e.g. phone call, paper/electronic form)
- Client information received with referral; adequacy of this information
 - PROMPT: Do you receive the Work Focused Health Related Assessment (WFHRA) from the provider or the client? Is it useful?

What is the size of your current caseload?

- Match with expectations
- Are caseloads manageable?
- What happens if caseloads reach maximum capacity? (e.g. waiting lists, referring people back to main provider, prioritising some clients)

What are the characteristics of clients referred to CMP?

- Proportion who are mandatory Pathways clients, voluntary Pathways clients
- Proportion of people with physical conditions, mental health conditions
- Other characteristics of those referred (e.g. wanting to work, lacking in confidence, main barriers to work)

What do you think about the appropriateness of referrals?

- What are appropriate referrals?
- What are inappropriate referrals?
- Suggestions for improving the appropriateness of referrals

Having talked about various aspects of referrals and caseloads...

- Any problems?
- Suggestions for improvements?

3. Delivering CMP**What happens after clients are referred?**

- How soon after referral are clients asked to attend a first appointment?
- Any assessment stage
 - o Do you use any standard assessment tools (e.g. Hospital Anxiety and Depression Scale (HADS))
 - o Can people be referred back at this point? Or referred/signposted elsewhere?
 - o Proportion of people referred who are caseloaded
- What information is given to clients about the range of support offered?
- Who decides what support clients will try? How far are clients involved in decision making?
- Is it possible to take up more than one kind of intervention? Simultaneously or sequentially

Can you tell me about the intervention(s) you are involved in delivering?

For each separate intervention:

- What does this intervention involve – what happens?
- Characteristics of clients who take it up
- How much is this intervention used (compared to others)?
- Where?
- Group or individual sessions – why this format?
- Number and frequency of sessions
- What happens if the client is receiving treatment/advice from other health services at the same time?
- How is client progress monitored?

- o Use of client development/action plans (content, frequency of review)
- o What client info is recorded and kept? Any issues about confidentiality
- Client outcomes

Do you talk to clients about work?

- At what stage? Probe for whether:
 - o throughout the programme
 - o introduced later as people progress through the programme
 - o at the very end, when the programme has been completed
 - o never
- What is discussed about work?
 - o PROMPTS:
 - the kind of work that would be suitable
 - what adaptations they may need at work
 - how their health condition could be managed at work
 - their rights under the Disability Discrimination Act
- Does talking about work have any impact on attendance at CMP sessions?

Would you say that challenging clients to think differently about their health, capabilities and the idea of returning to work is part of your role?

- How do clients respond to being challenged?
 - o Is it helpful? – e.g. encourages people to take steps towards/into work
 - o Does it hinder progress? – e.g. people drop out of the programme

Are there any other CMP interventions that you are not involved in delivering (including any delivered by other practitioners in the same organisation, or by a different organisation)?

- Do you have a role in referring people to these interventions?
- What do you know about these interventions?

What happens if clients fail to attend CMP meetings?

- Attempts to (re-)engage them
- Is the referrer notified?
- Numbers of people who are referred and never attend
- Numbers of people who attend at least once but miss some/all other sessions
- Perceived reasons for non-attendance

4. Ending CMP

What happens when CMP modules/sessions have been completed?

- Any assessment carried out to observe/measure client progress
 - Use of standard assessment tools (e.g. HADS)
- Referral back to referrer (i.e. Pathways adviser) - in all cases?
 - Any information fed back about client progress
- Referral/signpost to other sources of support
 - What kinds of support/which providers?
 - Relationship with these providers (e.g. service level agreement)
 - How often would this happen, in what circumstances?
 - Client information passed on
 - Views on quality and adequacy of other support; any problems; gaps in service provision

What happens if a client finds a job part-way through CMP?

- Would CMP sessions continue to completion?
- Referral/signpost: back to Pathways provider; to other sources of support
- Any contact with employers?
- Do people come back to you for help when in work?

What happens if a client loses entitlement to IB/ESA part-way through CMP?

- Would CMP sessions continue to completion?
- Referral/signpost: back to Pathways provider; to other sources of support

Where in-house, move to Section 6

Where sub-contracted:

5. Working relationships with Pathways provider staff

What contact do you have with staff at the Pathways provider?

- Who with? At particular offices?
- Purposes of contact
- How often?
- Usefulness of contact

What are your views about your relationships with Pathways provider staff?

- What helps/hinders relationships?
- How could relationships be improved?

6. Staff support and supervision

In what ways are you supported in your role?

- Formal methods (e.g. case conferences) and/or informal methods (e.g. conversations with colleagues)
- *Where CMP is in-house*: Contact with other provider staff and level of involvement with the rest of the Pathways programme
- Suggestions for changes to support

In what ways are you supervised?

- Formal methods (e.g. performance reviews) and/or informal methods (e.g. conversations with line manager)
 - o Probe for any clinical supervision
- Do you have any personal performance targets to meet? What are they?
- Are these targets achievable?
- What helps/hinders your performance?
- What would help to improve your performance?
- Any 'cultural clashes' between clinical interests and business interests?

7. Overall reflections

What helps people attend CMP and engage with the support offered?
What hinders attendance and engagement?

What kinds of impact does CMP make on people?

- Changes in health
- Changes in well-being
- Changes in readiness for work
- Any particular kinds of people who benefit most?
 - o Any differences in terms of client characteristics (see separate list)?
- Any particular interventions that are key to achieving these impacts?

Do you have any other views about what works well in the organisation and delivery of CMP?

Is there anything that is not working well?

- People who do not benefit from participation in CMP
 - Any differences in terms of client characteristics (see separate list)?
- Interventions that are making little impact
- Problems with delivery or relationships
- Gaps in service provision

Are there any changes that you would you like to make to CMP?

Thank you very much.

Check they are happy for their views to be included in our work.

B.8 Client topic guide



Provider-led Pathways CMP study Topic Guide: CMP participants

Interviewer's introduction

- Explain that this research is funded by the Department for Work and Pensions, and is one part of their overall evaluation of Provider-led Pathways to Work – a programme running for people on incapacity benefits or Employment Support Allowance.
- SPRU is an independent research organisation.
- This interview is part of a study investigating how the Condition Management Programme within Provider-led Pathways is being experienced. Researchers have already met with a number of CMP practitioners and managerial staff, and other staff working on the Pathways programme, in four areas of the country. We are now interviewing people who have taken part in CMP to learn about their experiences and views.
- Our discussion today will concentrate on:
 - when you first learned about CMP and your initial impressions
 - your experiences of attending CMP sessions
 - any other support you have received since you were referred to CMP
 - your reflections on any impacts that CMP has made for you
- The discussion will take around 60 minutes.
- Ask for permission to use recorder. Explain that recordings will be typed up professionally and seen only by the research team.
- Explain confidentiality and how material will be used – a report for DWP in which their views are included, but they will be anonymous.
- Taking part is completely voluntary.
- Check informed consent. Ask them to sign the consent form.

If asked what we mean by 'complying with the Data Protection Act' explain that we will:

- *keep all data in a secure environment;*
 - *allow only members of the research team (including administrators and transcribers) access to the data;*
 - *keep the data only as long as is necessary for the purposes of the research and then destroy it.*
-

1. Background information

- Household
- Age
- Brief employment history and current employment situation
- Reasons for claiming incapacity benefits, including health problems
- Perceived main barriers to work at the time benefits claimed
- Current benefit claims

2. Learning about CMP

How did you first learn about CMP?

(e.g. from the Pathways adviser; a friend; another service provider; a leaflet or other literature)

- If from a Pathways adviser: How long after you started going to [Pathways provider] was this?
- If not from a Pathways adviser: Did you speak to a Pathways adviser about CMP before you attended the first appointment?
- Thoughts about work at this time

What did you learn about CMP at this time?

- Understanding of the purpose of CMP
- Kinds of support offered
- Understanding about whether clinical treatment would be available or not
- Who would be delivering the support
- What did you think about CMP when you first heard of it?

Why did you decide to attend CMP sessions?

- Probe for:
 - o expectations about impact on health condition
 - o expectations about helping to prepare for work
 - o influence of Pathways adviser
 - o believing attendance was mandatory
 - o understanding that attendance was voluntary
 - o 'nothing to lose'

3. Contact with CMP staff

3a. For all participants:

How did CMP staff first get in touch with you?

(e.g. phone call, letter, face-to-face during WFI with Pathways adviser)

- What was discussed at this time?
- Usefulness

I'd like to talk about your first CMP appointment.

- When was it?
- Where?
- Who did you meet?
- What happened during this meeting? Probe for:
 - o discussion of health
 - o discussion of which interventions/kinds of support would be appropriate
 - o awareness of any assessment
 - o awareness of giving consent to take part in the programme
 - o awareness of any action plan, and of own/CMP staff responsibility to take action
- Did you discuss work in this first meeting? ★
 - o Who initiated this discussion?
 - o What was discussed?
 - o Views about this discussion (e.g. Did they welcome this discussion? Did it feel appropriate at the time? Did they feel pressured to think about work before they were ready?)

What was the outcome of this meeting – what would happen next?

- Probe for
 - o further meetings with CMP staff
 - o referred back to the Pathways adviser who had referred them to CMP
 - o referred/signposted somewhere else (e.g. GP/health care provider, other service provider)
- Why was this decision made?
- Did you feel involved in deciding what would happen next?
- How did you feel at the end of this session? (i.e. enthused, disappointed, that it had been a waste of time?)

What were/are your expectations about further CMP sessions/referral back to adviser/referral elsewhere?

Can I check, since that first meeting have you attended any more CMP sessions?

If the participant has attended only the first session:

- What was helpful about the meeting you had with CMP staff?
- What was not so helpful?
- Any problems (e.g. language; accessibility to premises; travel)
 - o Did you raise any problems/make complaints to CMP staff or the Pathways provider?
 - o How were these dealt with?
- Views about staff delivering sessions
- Views about premises and location (i.e. finding the venue, accessibility, environment inside)

Now move to 3c.

If the participant has attended further sessions:

- How many?
- How often do/did you attend?
- When was your most recent appointment?
- Staff met – whether the same each time.

Now continue with 3b

3b. For people who have attended more than the first CMP session:**What happened in subsequent CMP sessions?**

- Kind of help received. Probe for:
 - o counselling/talking therapy
 - o advice about exercises to ease physical conditions
 - o advice about managing pain (e.g. discussions about medication)
 - o advice about managing stress and anxiety (e.g. relaxation techniques)
 - o help to boost confidence
 - o advice about healthy living
- Duration of sessions
- Format: i.e. individual or group sessions; general or specific health condition sessions
- Was a record of your activity/discussions kept?

★ Did you discuss work during any of these sessions?

- When - which sessions?
- Who initiated this discussion?
- What was discussed?
- Views about this discussion (e.g. Did they welcome this discussion? Did it feel appropriate at the time? Did they feel pressured to think about work before they were ready?)

For each different kind of intervention:

- What was helpful?
- What was not so helpful?
- Any problems (e.g. language; accessibility to premises; travel)
 - o Did you raise any problems/make complaints to CMP staff or the Pathways provider?
 - o How were these dealt with?
- Were these sessions appropriate for you?
- Views about staff delivering sessions
- Views about premises and location (i.e. finding the venue, accessibility, environment inside)

Are you expecting to have any more sessions?

If yes:

- How many?
- Expectations about what will happen in these sessions and outcomes

If no:

- Why? Probe for:
 - o maximum number of sessions reached
 - o moved into work
 - o lost entitlement to IB/ESA
 - o have chosen not to attend further sessions
 - How did they come to this decision? What are the barriers to further attendance ★
 - What happened during the last CMP session? Probe for:
 - o any discussion of next steps
 - o assessment of progress made
 - o three-way meeting with CMP practitioner and Pathways adviser
 - Did you know in advance that this would be your last CMP session? How?
 - o How did you feel about the sessions ending?
-

3c. For all participants:

Have you ever missed a CMP appointment?

- Reasons for non-attendance (e.g. health; travel problems; perceived inappropriateness)
- What happened when you did not attend? ★

For people who have since returned to work:

Have you had any contact with CMP staff since returning to work?

- Who initiated contact?
- How many times?
- Purpose(s)
- Usefulness

4. Other support

Have you had any contact with the Pathways adviser since you were referred to CMP?

- When? How often?
- Who initiated this contact?
- Purpose(s) of contact
- Usefulness

Have you received help from other sources (i.e. other Pathways services, or services outside Pathways including health services) since you were referred to CMP?

- When? How often?
- Who initiated this contact?
- Purpose(s) of contact
- Usefulness
- Views about whether this support was complementary to support received from CMP

5. Impact of CMP and final reflections

5a. For those not in employment:

What are your current thoughts/expectations about work?

- What are the main barriers to work at the moment?
- What help would you like to receive at the moment?

Would you say CMP has made any difference to you and your situation?

- Probe for making a difference to:
 - o health
 - o understanding and managing health condition(s)
 - o thoughts and plans about work
 - o social interaction
 - o confidence; motivation
- What was particularly helpful in making this difference? (e.g. staff support; short waiting time for entry to programme; meeting with other people in group sessions)
- Whether impact was short-lived, or has been longer-lasting

Have your expectations about CMP been met? Or exceeded?

Is there any other support that you have received that has been particularly helpful?

(e.g. health care services; other education and employment services; financial support; friends and family)

Would you recommend CMP to other people?

Are there any ways in which you think CMP could be improved?

5b. For those in employment:

Why did you decide to return to work – what was influential?

Did taking part in CMP play any role in helping you back to work?

- In what ways?
- Do you think you would have returned to work without taking part in CMP?

Has taking part in CMP helped you to stay in work?

- In what ways?

Has CMP had any impact on your:

- o health
- o understanding and management of health condition(s)
- o social interaction
- o confidence; motivation
- What was particularly helpful in making this impact? (e.g. staff support; short waiting time for entry to programme; meeting with other people in group sessions)
- Whether impact was short-lived, or has been longer-lasting

Have your expectations about CMP been met? Or exceeded?

Would you recommend CMP to other people?

Are there any ways in which you think CMP could be improved?

Thank you very much.

Check they are happy for their views to be included in our work.

References

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Providers in Provider Led Pathways areas are required to offer a Condition Management Programme (CMP) to their customers, similar to the CMP service delivered by the NHS in Jobcentre Plus led Pathways areas. Although there is a degree of freedom in how these programmes are designed and delivered by these providers, there is an expectation that Health Professionals deliver the programme and tailor it to meet individual customer needs, while ensuring it adheres to Department of Health Clinical Governance standards.

This research was designed to provide an understanding of how CMP is operating on the ground in Provider-led Pathways districts. The research was carried out by the Social Policy Research Unit in 2009. The study used individual and group interviews with Pathways and CMP staff and in-depth interviews with CMP clients.

On the whole, the findings from this study were similar to those from studies of CMP in Jobcentre Plus-led Pathways areas (DWP research reports, 346, 582). The findings show that CMP can help to improve people's well-being and readiness for work and appears to be an important part of Pathways to Work programme.

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