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RESEARCH ARTICLE

Employability through health? Partnership-based governance and the delivery of Pathways to Work condition management services

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The Pathways to Work (PtW) initiative has been rolled out in 49 Jobcentre Plus districts across Great Britain as the government seeks to provide services to activate claimants of incapacity benefits and help them overcome health-related barriers to work. The recent expansion of PtW has seen a heavy reliance on the contracting-out of services to the private and third sectors, with 'Lead Providers' paid according to job outcomes achieved for clients. However, during the initial development of PtW, the initiative was defined by a flexible, partnership-based form of governance, with a key role for the public National Health Service (NHS) in the delivery of health 'condition management' services. This approach has been retained in a minority of Jobcentre Plus Districts. Based upon a review of previous evaluation evidence and more than 50 in-depth interviews with NHS staff and managers, this article critically assesses this partnership-based governance model and the potential added value flowing from the involvement of the NHS and its professional clinicians in the delivery of condition management services. The article concludes by identifying lessons for the continuing development of governance and delivery mechanisms for condition management under the PtW regime and future employability/health interventions.

Keywords: employability; incapacity; welfare to work; activation; condition management

Introduction

The Pathways to Work (PtW) initiative was rolled out across Great Britain between 2003 and 2008 as the government's Department for Work and Pensions (DWP) sought to activate claimants of incapacity benefits (IBs).¹ The initial design of the initiative emphasised the importance of a Condition Management Programme (CMP) offering services to help participants to cope with and manage health problems – a reflection of policy-makers' acceptance that many of those claiming IBs faced substantial barriers to work related to both employability and health issues. The CMP model was developed in collaboration with the Department of Health and in pilot districts (and during the initial phase of the national roll-out of PtW) delivery was led by public-sector National Health Service (NHS) managers and professionals. The flexible funding and partnership-based governance of the CMP in these districts was, and remains, distinctive when compared to standard models of contracting-out favoured by the DWP under other welfare to work programmes (and

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in other parts of Great Britain where PtW is managed by private and third-sector delivery agencies).

Drawing on the literature on ‘new governance’ in employability services, a review of evaluation evidence and more than 50 in-depth interviews with NHS staff and managers, this article explores the dynamics of this partnership-based governance model and the potential added value flowing from the involvement of the NHS and its professional clinicians in the delivery of employability/health services. The aim is to explore the extent to which the involvement of a major public-sector body (rather than contracting-out to the private/third sectors) makes a difference; and to identify if there are lessons from this different approach to governance (which eschews ‘payment by results’ contracting in favour of collaboration).

Following this introduction, part two of the article describes the content and governance of CMP services under PtW. Part three locates the partnership-based approach described within the broader structures for (and debates around) the governance of employability services in Britain. Part four describes the methodology for the primary data gathering with NHS stakeholders before part five reports findings on the benefits and problems associated with the NHS CMP model. Finally, we identify lessons for the governance and delivery of future employability/health interventions.

Pathways to Work and condition management services

The rationale and content of Pathways to Work

PtW was piloted in seven delivery areas from 2003, before being rolled out across Great Britain by the end of 2008. All new claimants of IBs (and in some areas those who started claiming during the two years preceding the introduction of the programme) were initially eligible. As noted elsewhere in this special issue, the introduction in 2008 of Employment and Support Allowance (ESA) to replace existing IBs for new claimants means that a considerably higher proportion of those claiming such benefits will be directed towards some form of ‘active’ intervention as part of a ‘work-related activity group’. The ESA process has imposed a stricter Work Capability Assessment to replace the previous Personal Capability Assessment (see discussion below) so that more, and more disadvantaged, IB claimants will be directed towards PtW interventions.

The additional conditionality and compulsion associated with the ESA reform suggests a continuing focus within government on preventing IBs from disincentivising work. As Bamba (2008, p. 517) notes: ‘Despite evidence that medically certified sickness absence (including incapacity benefit) is actually a good indicator of health and mortality, political and media debates are dominated by the view that incapacity benefit is a disincentive to work’. Nevertheless, the suite of provision brought forward under PtW arguably saw the British government acknowledge – to some extent – that the rise in numbers claiming IB reflected a complex combination of problems around individuals’ employability and, *more specifically*, health-related barriers to work. The need for well-resourced, holistic solutions to this problem has been noted by those pointing to the ambitious nature of the government’s pledge to get ‘one million off benefits’. Fothergill and Wilson (2007) argue that employers are likely to be reluctant to recruit from IB client groups with relatively poor work

records (a problem accentuated during recessions where the supply of labour outstrips demand). Those conducting research with IB clients have also pointed to their diversity (and therefore the diverse range of problems faced by individuals) across different age and gender groups (Brown *et al.* 2007, Beatty *et al.* 2008). For example, it has been noted that women within the IB client group are more likely than their male counterparts to report mental health problems (Fone *et al.* 2007). Research with the client group also suggests that many face a complex combination of barriers to work linked to health, but also skills gaps, low levels of educational attainment and caring roles (Davidson 2006). The government claims that PtW provides a ‘holistic approach’ to providing intensive support for these people (HM Treasury 2005).

Accordingly, PtW provision will continue to form a key component of services for those claimants directed towards ‘work-related activity’. The content of PtW currently includes:

- a compulsory assessment interview, followed by five compulsory work-focused interviews with advisers working for Jobcentre Plus or a contracted provider;
- voluntary access to short ‘Choices’ training options (e.g. ‘work preparation programmes’ that provide basic employability skills and preparation for the workplace, delivered in partnership with training providers and employers; and access to New Deal for Disabled People provision);
- a one year ‘Return to Work Credit’ paid at £40 per week tax-free for full-time work for those earning less than £15,000 per year;
- the CMP – a 6–13 week voluntary intervention designed to enable clients to cope with mild/moderate health conditions. The CMP is not designed to replace standard health interventions; rather it uses cognitive behaviour therapy (CBT)² related techniques to challenge negative attitudes and help clients to learn to cope with conditions in such a way that they may return to some form of employment.

The CMP was initially highlighted by government as vital to the holistic approach to helping IB claimants under PtW – a ‘balanced package which aims to target a number of health-related, personal and external barriers to returning to work’, with ‘new programmes, delivered in partnership with the NHS’ a key element (DWP 2006, p. 28). As noted above, the CMP offers a range of services for participants, but is largely built around the principles of CBT. Recent trials of CBT-related approaches have found positive benefits for workless individuals in relation to improved confidence and perceived employability (Clark *et al.* 2006). The broader evidence base is somewhat mixed. Cognitive therapeutic approaches, deployed among severely disadvantaged groups, have been found to have positive impacts on ‘soft’ employability characteristics such as self-efficacy (Washington 1999). However, Harris *et al.* (2002) found no significant impact in terms of job entry when comparing long-term unemployed people receiving CBT-related interventions with a control group, although the authors acknowledge the severe health and other barriers faced by the client group, and the short duration of the intervention (11 hours over two sessions) may have been inappropriate for such clients. Nevertheless, there is general acceptance that CBT-related approaches have the potential to be effective in helping

those with mild/moderate health problems to better understand and cope with their conditions (Winspear and Robertson 2005).

The CMPs delivered by health professionals in those Jobcentre Plus districts where the NHS was involved in PtW were based around CBT-related approaches, informed by a so-called ‘five areas’ therapeutic model developed as part of an NHS commission to provide an accessible approach to CBT (Williams 2001). The model provides a structure to consider the problems faced by clients across five domains:

- their life situation, personal circumstances, practical problems;
- altered thinking (self-esteem, confidence, pessimism);
- altered feelings/mood (depression);
- altered physical symptoms (sleeplessness, anxiety, reduced energy);
- altered behaviour (reduced social or work activity).

As we will see below, the CMP has been relatively marginal to the overall operation of PtW in terms of numbers of clients engaged. However, the importance of health-focused employability provision under PtW is likely to grow as: (a) Jobcentre Plus and its providers increasingly target not just new benefit claimants, but the ‘stock’ of claimants who have been receiving IBs for long periods; (b) the ESA regime directs an increasing number of new claimants, many reporting complex health problems, towards work-related activity. As importantly for the purposes of the remainder of this article, *how* the CMP has been managed and delivered in some parts of the country stands in sharp relief to the dominant forms of contractualism that characterise the governance of employability policy under other programmes.

The governance of the Condition Management Programme

The DWP approached the Department of Health to develop the design of the CMP in PtW pilot districts. Department of Health experts and DWP staff worked together to develop a condition management model that was based on best clinical practice in CBT and occupational health. In the first 18 districts in Great Britain where PtW was piloted and subsequently rolled out the overall initiative was led and managed by Jobcentre Plus. In all of these districts the CMP element of PtW was developed and continues to be delivered by NHS organisations, with NHS clinical professionals taking a lead role in implementing the programme. In these districts relatively flexible memoranda of understanding define the relationship between Jobcentre Plus as funder and NHS organisations as deliverers. Jobcentre Plus managers and NHS organisations agree client engagement and progression targets, but there are no job entry or outcome requirements attached to funding. The Jobcentre Plus–NHS CMP model has been highlighted as an example of innovative practice in promoting partnership-based approaches to delivering employability/health services. As Lindsay *et al.* (2008, p. 724) note:

The funding and management model established by Jobcentre Plus ... appears to have been crucial to facilitating co-operation between the agencies. At the outset of the pilot, managers agreed to replace standard contractual models with more flexible financial structures, allowing NHS managers considerable freedom in the recruitment of staff and resourcing of programme development ... For NHS stakeholders, the autonomy given to CMP managers to manage their own budgets enabled staff to move between roles in order to address service gaps without delay, and allowed for the modification of

programme content to meet clients' needs. For [Jobcentre Plus] managers, there was value in experimenting with more flexible partnership models that reduced the need for contract management and bureaucratic 'hand offs' (formal procedures transferring responsibility for clients between agencies).

Despite these apparent benefits, the government made clear that the continuing roll-out of PtW would depend on more familiar models of contracting-out. Relatively early in the initiative's roll-out it was confirmed that 'future PtW provision will be delivered primarily by the private and voluntary sector with payment by results' (DWP 2006, p. 6). Accordingly, in the remaining 31 British districts in which PtW was launched private and third-sector Lead Providers were contracted by the DWP to lead the overall management and delivery of the initiative. Lead Providers were set and agreed to challenging job outcome targets, which they have struggled to meet (see below), with 70% of funding linked to the achievement of a set number of job entries. The majority of this outcome funding (50% of total funding) was linked to immediate job entries, with the remainder (20% of total funding) paid if work was sustained by clients for 13 weeks. Policy-makers pointed to the relatively flexible arrangements for the internal management of funding by Lead Providers (a so-called 'black box' model, which allowed lead agencies to manage their own resources and develop locally responsive services). It was suggested that this model would allow Lead Providers to work with specialist delivery agencies, including NHS organisations where appropriate (although only one contracted Lead Provider in fact collaborated with NHS organisations to deliver the CMP).

It is difficult to find detailed evaluation evidence on the performance of different PtW and/or CMP governance models. However, with the onset of a severe recession, it is clear that contracted providers have failed to achieve the targets set by government. Data released in early 2009 suggested that the contracted-out programme was running more than 70% below targets, resulting in major cash flow problems for some 'payment by results' providers.³ As for the CMP element of the initiative, the most striking feature is that it has been relatively under-used. Despite being initially described by DWP officials and Jobcentre Plus managers as central to the PtW model (Lindsay *et al.* 2007), by September 2008 only 6% of PtW clients had been referred to CMP services (with around three-quarters of these people actually starting the programme). This is not to say that the CMP has been marginal within the 'Choices' employability options of PtW – it has accounted for approximately 40% of 'Choices' participants (DWP 2008). But the reality is that the majority of PtW participants have either not chosen to participate in 'Choices' options (or have not been signposted to such provision by advisers), or have progressed into work and/or left benefits following compulsory work-focused interviews. There are no comprehensive evaluation data comparing practice or outcomes achieved in NHS and Lead Provider-led CMP districts.

New governance and the delivery of employability services – where does Pathways to Work fit?

New forms of governance have come to define reforms to the administration of employability services in many EU states. With unemployment falling during most of the 2000s, policy-makers began to turn to the problems of 'harder-to-reach' groups

(Van Berkel and Valkenburg 2007). The belief is that hard-to-reach groups require tailored, individualised services that respond to their specific combination of barriers to work, just as disadvantaged areas need localised programmes that reflect the dynamics of local labour markets. Accordingly, there is agreement that new forms of governance have the potential to improve services by: encouraging more flexible organisation and the decentralisation of decision-making; including a wider range of stakeholders with specific expertise in the planning and delivery of provision; and tapping the dynamism of the private sector (Van Berkel and Borghi 2008). The increasing use of contracting-out as a means of including new stakeholders in the delivery of services has been central to the new governance agenda in many states, and is particularly clear in the British case.

The Labour government elected in 1997 has pursued a new governance agenda dominated by the increasing use of markets, outsourcing of service provision to the private and third sectors, contracts with by 'payment by results', and decentralised delivery (Evans 2009). In terms of the specific field of employability and labour market policy, contracting-out is seen as vital to making individualised, personalised support work – it is argued that the inclusion of private and third-sector bodies in the delivery of employability provision (combined with increasingly intensive personalised case management) has brought 'unprecedented levels of individual choice into the system', with PtW consistently highlighted as an example of good practice in this respect (DWP 2006, p. 74). As Driver (2009) notes, the focus on marketisation and contestability in employability services has intensified in recent years, in the wake of the government-commissioned Freud Review into welfare reform (Freud 2007). The Freud Review started from the assumption that contracting-out can deliver innovation and the 'potential to engage with groups who are often beyond the reach of the welfare state', despite an early acknowledgement that 'there is no conclusive evidence that the private sector outperforms the public sector on current programmes' (Freud 2007, p. 6). From this perspective, 'the market is better able to judge the costs and benefits of getting individuals back to work; and competition between providers will deliver more efficiently and effectively' (Driver 2009, p. 79). This approach – despite its weak evidence base – has been welcomed by both Britain's major political parties (Conservative Party 2008, DWP 2008). Yet there remains substantial international evidence of the potential downside of wholesale contracting-out, from providers' 'creaming and parking' of clients to achieve job outcome targets (Daguerre and Etherington 2009) to processes of 're-bureaucratisation' and substantial transaction costs linked to complex contracting arrangements (Wright 2008). It has also been noted that contracting-out (especially to for-profit providers) often seems to go hand-in-hand with an increasing focus on 'Work First' approaches, which seek to 'encourage' job-seekers to take any form of available work with little regard for the quality or sustainability of outcomes (Sol and Hoogstanders 2005).

Despite this commitment to contracting-out, British policy-makers have also sought to adopt the language of partnership to describe multi-agency working on employability, and have prioritised engaging public-sector stakeholders (from local authorities and health organisations to registered social landlords) in an attempt to promote active approaches to combating worklessness across a range of local policy agendas (DWP 2008). The problem is that it is unclear whether attempts to build local partnerships on the one hand, and contracting-out mainstream services on the other, are always complementary or even compatible. Lindsay *et al.* (2008) argue that

the ‘capacity for mutualism and co-operation’ is essential to effective partnership-working – those involved need to have both the authority and institutional flexibility to engage in mutual decision-making and the sharing of ‘ownership’. Contracting-out can sometimes run counter to building such shared ownership.

PtW has been described as something of a hybrid of Work First and more holistic approaches to promoting employability (Lindsay *et al.* 2007), while its governance arrangements range from large-scale contracting-out involving for-profit providers to partnership-working between Jobcentre Plus and the NHS. It is the latter form of governance that provides the focus for the remainder of this article. The partnership-based governance that allowed for the inclusion of NHS organisations in the delivery of PtW in a number of districts provides an interesting contrast to the centralised contractualism that defines the delivery of this and other DWP-funded programmes elsewhere. In a ‘post-Freud’ environment, the discussion below allows us to consider the potential value of non-contractual approaches to organising employability/health services, as well as the potential added value associated with partnership-working between key public-sector organisations. Our review of evaluation research and new data helps us to explore whether a re-engagement with genuine partnership-working, based on shared goals and equal access to information and decision-making, has the potential to offer an alternative to marketisation and contractualism. If such partnership-based forms of governance are workable, they may offer a means of ensuring that stakeholders are included in the delivery of welfare reform not just because of their effectiveness in operating in the marketplace, but because of their expertise in assisting people towards work and health.

Researching partnership-based governance under Pathways to Work

Semi-structured, qualitative interviews were selected as a means of exploring the experience and practice of NHS professionals involved in PtW partnerships. Such approaches ensure consistency in how issues are explored with interviewees while allowing flexibility to probe and pursue specific themes. Interviews were conducted with 52 CMP practitioners involved in the delivery of PtW condition management services across five Jobcentre Plus districts in England (10 interviews), Scotland (33 interviews) and Wales (nine interviews). Interviews were also conducted with senior NHS managers with overall responsibility for CMPs in three districts in Scotland. The initial focus of the study was the practice of NHS professionals under PtW in Scotland, reflecting an effort to build on previous work undertaken by members of the research team (Lindsay *et al.* 2007, 2008, Lindsay and McQuaid 2008). However, additional fieldwork was undertaken in England and Wales in order to explore how different organisational contexts shaped CMP practitioners’ experiences – in some parts of England, one Primary Care Trust has taken the lead on behalf of a number of trust areas contained within a given Jobcentre Plus district; trusts similarly lead CMPs in Wales (in partnership with Local Health Boards); while in Scotland NHS Boards have appointed Project Managers, with CMP teams often, but not always, located within the organisational structures of Community Health Partnerships. Interviews were conducted between November 2007 and April 2008, at a time when CMP partnerships in all areas were well-established. The same delivery structures remain in place in all study areas at the time of writing.

Given the considerable scale of Jobcentre Plus districts, and the manner in which they cover a range of urban and rural areas, interviewees were asked about the general geographical context for their work, and are thus identified below in relation to their practice in an 'urban area', 'rural area', etc. The role of practitioners (13 of whom were 'Team Leaders' acting as first line managers for CMP teams) is also identified where interviewees are quoted, along with their area of clinical expertise. Interviews covered the role and practice of NHS professionals involved in the delivery of the CMP; strengths and weaknesses of the governance, content and structure of condition management services; outcomes achieved and barriers faced by clients; partnership-working with Jobcentre Plus, NHS organisations and other stakeholders; and priorities for the future development of services. Key issues raised under these themes are discussed below, with individual interviewees quoted in order to illustrate areas of consensus across the overall sample or among particular respondent groups. The average duration per interview was approximately 50 minutes. Interviews were undertaken in a private area within interviewees' workplaces or in quiet, private spaces outside work. Interviews were transcribed and analysed using *QSR NVivo 7.0*.

Findings: added value through partnership-based governance?

Added value through National Health Service clinical expertise and capacity?

Previous evaluation work has pointed to advantages associated with the involvement of NHS professionals in the delivery of CMP services (see, for example, Barnes and Hudson 2006). Our interviews with CMP practitioners highlighted a number of potential benefits associated with the credibility, professionalism and expertise brought to the table by NHS staff. At a basic level, many interviewees spoke of the 'NHS brand'. Feedback from CMP clients and Jobcentre Plus advisers had suggested that the NHS 'brand' brought a degree of credibility to the programme in these districts. A number of interviewees pointed out that, for many among the client group, the NHS was the *only* organisation that they associated with healthcare services.

For some people, if they are receiving a service from the NHS then that's the route to getting better for them. For most people it's the only health service they will really know about, so the association is with getting better. They think 'it's the NHS, I am going to get better'. (CMP practitioner, general nursing background, peri-urban area, Scotland)

Another CMP practitioner argued that: 'clients have a healthy respect for the NHS and they expect that as it's health problems it will be NHS professionals that are looking after them' (CMP practitioner, general nursing background, peri-urban area, Scotland). A very small number of interviewees suggested that clients' previous negative experiences of NHS services could act as a barrier to engagement; but in the vast majority of cases clients' attitudes towards the NHS were defined in terms of 'trust' and a belief in the organisation's 'professionalism', 'integrity' and 'credibility'. CMP practitioners described how clients who were 'unwell' were reassured that a 'health professional' was dealing with their problem. There was a sense that clients felt better able to discuss sensitive health issues with NHS professionals.

I think people see your NHS badge and there's that element of trust there – you're working with someone who's professional and who has experience of working with people with different health conditions. (CMP practitioner, occupational therapy background, urban area, England)

For some CMP practitioners, the culture and reputation of the NHS as an organisation provided an important counterpoint to the approach of Jobcentre Plus and its contractors. The view was that clients saw the NHS as a well-established organisation, independent of Jobcentre Plus. It was also suggested that Jobcentre Plus could be seen by some clients as being committed to 'encouraging' clients to enter work at all costs, whereas NHS practitioners were trusted to focus on improving individuals' health.

It makes people feel at ease, takes the pressure off. They know that we are not going to force them into work. We explain that for us it is about helping them manage their health conditions better, with a view to exploring routes into work. They understand that it is work-focused but that we will not force them into work. (CMP practitioner, disability nursing background, urban area, Scotland)

Clearly these findings need to be treated with caution. Interviewees could only tell us about their perceptions of clients' experiences and views. There is a need for further research with clients themselves, but previous evaluations have suggested that CMP participants have been broadly positive about interactions with NHS services and professionals (Corden and Nice 2006, Warrender *et al.* 2009). Relatively few CMP practitioners drew a distinction between the NHS and those private-sector bodies managing the CMP in some other PtW districts, although five interviewees did see the public-sector ethos of the NHS (and the obvious not-for-profit culture of the organisation) as a positive selling point when engaging with clients.

NHS [is] a safe pair of hands. It's also perceived as something non-profit making and that again adds value because you are not making money out of it. And it does make a difference because it is something you are familiar with and something they are too, that it's free at the point of contact. (CMP Team Leader, community nursing background, urban area, Scotland)

They appreciate that we are not a business that's out to make money whether they get better or not. There is a trust there. (CMP practitioner, general nursing background, peri-urban area, Scotland)

Nevertheless, most CMP practitioners saw few major problems with some, or even considerable, private-sector involvement in the delivery of provision. But while interviewees did not generally insist that the NHS was the only organisation capable of leading CMPs, they were more certain that NHS staff and/or other clinical professionals should be an essential element of the programme. NHS managers and staff consistently pointed to the additional skills and experience entailed in being a clinical professional. A number of interviewees spoke of the importance of being able to 'read' clients – i.e. pick up on verbal signs and body language in order to grasp the level and form of (often undeclared) health problems faced by people. It was also suggested that NHS professionals brought clinical expertise and experience, an embedded commitment to clinical governance standards, and crucially an understanding of 'why' as well as just 'how' certain approaches were likely to work.

I don't see myself as any better than people in other agencies who may want to help. But I hope that I bring a lot more to it than just the five areas training [i.e. basic training in the principles of CBT-oriented approaches]. There is NHS training and clinical governance standards. I am a nurse and I bring that training and knowledge to it. We have the expertise in evaluating and responding to people. I think that if you do not have a clinical background you might struggle. I am a qualified nurse and I find it challenging. (CMP practitioner, general nursing background, peri-urban area, Scotland)

It should be pointed out that clinical professionals were not seeking a monopoly on the delivery of CMP provision. In two of our participating districts, support workers (or 'technicians' as they were sometimes termed) had been trained to deliver some aspects of the CMP, under the supervision of clinical professionals. There was agreement that this approach added value, providing valuable support for clinical professionals, but a consistent commitment to the idea that the more embedded knowledge, clinical judgement and experience of health professionals was a necessary element of an effective, and *safe*, CMP.

You can kind of tell somebody's just saying what they think you want, they want you to hear. And that comes from just working in a clinical environment . . . you've got to be able to actually tease that out from them. The other thing that I think, and this is from my own experience, is that people without a professional or clinical background don't maybe always just see the bigger picture. Like how one event does affect another event and maybe the importance of some of the things that people say to you . . . I have worked with some really, really good support workers, but in all honesty I don't think that they could provide at the same level that we do. (Senior CMP practitioner, general nursing background, urban area, Scotland)

While there may be an element of territoriality in such views, and (as noted above) many practitioners were actually supportive of the role of non-clinicians, there is some evaluation evidence to suggest that the range of knowledge brought to bear by clinical professionals can make a difference in the eyes of clients (Warrender *et al.* 2009). In terms of benefits for clients, CMP practitioners reported a familiar range of positive outcomes, while also registering their concern that the programme as currently constituted could not help some more disadvantaged individuals. Among those reporting positive outcomes, benefits included: improved functioning, pain management and general coping with conditions; better understanding of conditions; improved mood and reduced anxiety (with significant changes measured using HAD⁴ and other tools); increased confidence and self-efficacy; and greater stability that sometimes contributed to progress towards and into work.

Similar benefits have been reported in some earlier evaluations of the PtW CMP (Barnes and Hudson 2006, Corden and Nice 2006). That said, in terms of job outcomes, quantitative evaluation evidence of all PtW CMP provision (NHS and contracted-out) does not appear encouraging at first sight. For example, Adam *et al.* (2009) report no significant positive employment effect associated with CMP participation – indeed participants appear less likely than other PtW clients to enter work. However, the same authors note that this may be predictable given that the CMP is likely to serve some of PtW's most disadvantaged clients, who are furthest from the labour market – one evaluation estimated that only around half of CMP participants were actively seeking to move towards work at the start of the process (Bailey *et al.* 2007). Furthermore, a Department of Health-supported evaluation of CMPs run by the NHS confirmed

that participation was ‘associated with a significant reduction in anxiety and depression’ and improved confidence and coping, which were in turn associated with an increased work-readiness (Ford and Plowright 2008, p. 11). The same evaluation found that, among a limited sample of clients, two-thirds had made progress towards or into work, with one-fifth having found work during or immediately after completing the CMP.

Evaluation evidence remains sketchy and sometimes contradictory (and the outcomes reported for CMPs must be understood in the context of a programme addressing the needs of a minority of hard-to-reach PtW clients); but there appears to be some evidence that CMP services can make a difference for IB claimants with health problems. It may be that the content of such programmes is enough to help some individuals to cope better and move towards work – it has previously been suggested that the principles of CBT-oriented interventions for job-seekers can be ‘taught within days’ to employability professionals with a psychology background (Terry 1999); and Clark *et al.* (2006) have accordingly called for a rapid expansion of community-based CBT provision. However, our analysis makes a strong case for retaining some role for NHS/other clinical professionals at least in the management and supervision of CMP services. As we will see below, retaining the skills, expertise and capacity offered by the NHS may also require a re-commitment to partnership-based governance, rather than the large-scale contracting-out that policy-makers often take as their starting point for the organisation of employability services.

Added value through partnership-working under Pathways to Work?

Our research also sought to probe how relationships with Jobcentre Plus, NHS organisations and other stakeholders (and the governance structures that framed these relationships) impacted on the delivery of the CMP. Previous research in CMP pilot districts highlighted the manner in which the relatively flexible governance regime adopted within Jobcentre Plus–NHS partnerships facilitated the effective delivery of services for IB claimants. As noted above, Lindsay *et al.* (2008) reported how NHS managers saw the partnership-based approach adopted for the CMP as facilitating co-operation and promoting trust, simplifying financial arrangements and bureaucracy, and promoting flexibility and dynamism in the delivery of services. The result was a partnership that promoted autonomous practice and where Jobcentre Plus (as funder) supported ‘constructive change’ during the planning and delivery process (Barnes and Hudson 2006). Similar benefits were acknowledged by senior managers and experienced practitioners participating in our research, who identified autonomy in staffing and the resourcing of engagement activities as being facilitated by a flexible approach that would not have been possible under more rigidly-defined contracting. CMP practitioners were often pleasantly surprised by the autonomy afforded them and the flexible way in which condition management was planned and delivered.

We are free to develop the CMP as long as it fits within the broad model and objectives as agreed. Within the CMP framework we have a lot of freedom and flexibility. They [DWP/Jobcentre Plus] would never interfere and I would not expect them to. (CMP programme manager, community nursing background, peri-urban area, Scotland)

The structure is flexible. I am still able to apply my occupational therapy skills. We mix and match. We have the autonomy to be flexible. (CMP practitioner, occupational therapy background, urban area, Scotland)

More specifically, CMP practitioners pointed to the considerable autonomy that they enjoyed regarding the management and organisation of their workload and the particular mix of therapeutic approaches adopted with each client; CMP managers spoke of their autonomy on budget, recruitment and staff management issues, as well as a programme design that allowed for flexibility in how services were organised and the content of provision. CMP practitioners also described a culture of collaboration and partnership-working with Jobcentre Plus staff and managers. In most cases, there were effective (both formal and informal) communication networks between advisers and CMP practitioners. While knowledge of the CMP among Jobcentre Plus staff and managers was limited at the start of the programme, awareness of (and referrals to) the programme had generally increased with time. Many CMP practitioners had undertaken job shadowing or joint assessment/referral exercises with Jobcentre Plus advisers, resulting in improved understanding of each other's roles and a reduction in inappropriate referrals. For a small number of CMP practitioners in one rural district, relationships of trust had been more difficult to establish with Jobcentre Plus, resulting in relatively low referral rates well after the launch of the CMP. While these experiences were very different from the more positive relationships reported elsewhere, there is a clear need to quickly tackle problems where partnership-working between Jobcentre Plus and CMP deliverers has broken down.

A number of CMP practitioners noted the lack of pressure to achieve job entries or other outcome targets, and generally thought that this added to positive relationships between the NHS and Jobcentre Plus (as well as allowing practitioners and clients to focus on working together to improve health). Practitioners were generally aware that their Jobcentre Plus colleagues worked within a more target-oriented culture, and that other aspects of clients' experiences of PtW involved compulsion. A very small number of practitioners raised concerns that some clients had felt compelled to attend an initial CMP interview. However, the vast majority of interviewees detected no compulsion, although a number noted the close working relationship between some clients and Jobcentre Plus advisers, which it was thought could lead to some people participating in the programme in an attempt to please Jobcentre Plus staff.

Sometimes you get the feeling that clients are trying to score 'brownie points' with the PAs, but they seem to understand that it's voluntary. They have the right information. (CMP practitioner, general nursing background, peri-urban area, Scotland)

Partnership-working with other NHS stakeholders was also important. For CMP practitioners, the range and scope of expertise within the NHS provided easy access to expert knowledge on different health problems. A number of interviewees described instances where they had used NHS systems to identify local experts who they approached for advice on specific conditions. The NHS organisational context also allowed practitioners to signpost (although not formally 'refer') clients to appropriate additional provision. That said, there was some suggestion of a need to connect more effectively with community health services and networks in some areas. Improving awareness of the CMP (and eligibility criteria) among other NHS

organisations was a priority for senior practitioners and managers in a number of our study districts.

Interviewees in a number of study districts also acknowledged how partnership-working with Jobcentre Plus had promoted innovative practice within the NHS itself. As noted in previous studies, the CMP model is seen as a form of self-help and empowerment rather than ‘treatment’ as delivered through the traditional ‘medical model’. The aim is to ‘de-medicalise’ how NHS professionals support individuals (Lindsay *et al.* 2007). These principles were acknowledged and welcomed as appropriate given the specific priorities of the CMP. Interviewees saw de-medicalisation as embodied in both the design of the programme and the practical arrangements and locations for its delivery. For one interviewee ‘getting away from the medical model [was] crucial’ (CMP practitioner, physiotherapy background, urban area, England) to the design and content of the CMP – previous evaluations have similarly pointed to how the flexible, multi-intervention approach of the programme represents a journey into ‘waters previously uncharted by the NHS’ (Barnes and Hudson 2006, p. 27). For another NHS manager the de-medicalisation agenda affected how and where the CMP was delivered.

There is an evidence base to suggest de-medicalising the whole thing. It is about what you can do and not worrying about what tablets to take. So we don’t do medical centres . . . we wanted to try and forge a relationship with the client that’s different from the current support they’re getting. So we think it should be somewhere else. We primarily either use rented office space or community centres. (CMP programme manager, community nursing background, peri-urban area, Scotland)

These findings demonstrate that partnership-working between public-sector organisations has made a difference to how CMPs in these districts have worked. Clearly, there is a need for further research with clients on the extent to which Jobcentre Plus–NHS partnerships have been able to deliver a seamless, effective overall service; and if and how a de-medicalised intervention delivered by NHS professionals adds value to pre-existing health and employability provision. Nevertheless, our research suggests that there may be benefits. Relationships between individual practitioners and advisers have largely been defined by collaboration and trust, an approach facilitated by the absence of rigid contractual obligations or outcome targets. The funding and governance structures for the programme have allowed NHS professionals and managers a degree of flexibility and autonomy in shaping provision. Finally, the involvement of NHS professionals has enabled additional partnership-working, tapping the NHS’s wider capacity and expertise. There is some evidence to suggest that these benefits would simply not be available without the partnership-based approach pioneered by Jobcentre Plus and the NHS in our study districts (see also Lindsay *et al.* 2008).

Limits and problems of National Health Service-led condition management services

However, the NHS professionals and managers participating in our research did not see the current CMP model as a panacea for health-related barriers to work. The considerable flexibility afforded to those delivering the programme was again acknowledged, as was the need for certain agreed core elements, and there was broad support for CBT-oriented approaches. Yet despite this flexibility, it was noted

that the CMP model, with its core CBT principles, was not always appropriate for some clients. There was a sense that ‘some clients just don’t grasp CBT’ (CMP Team Leader, community nursing background, peri-urban area, Scotland). CBT-related work requires a particularly high level of engagement from participants, which can be difficult to achieve given the complex health and other barriers faced by PtW clients. Hawton *et al.* (1988) note the importance of individuals’ commitment (and willingness to follow through on agreed actions) to making cognitive behavioural interventions work. Harris *et al.* (2002), focusing more specifically on the value of CBT-related interventions in helping long-term unemployed people, note that clients need to be ‘psychologically ready’ and ‘seeking to change’. CMP practitioners accepted that some clients were simply ‘not yet ready’ to make progress, which was reflected in variable success and attendance rates. Even among those clients engaging with the CMP, failure to attend specific sessions or complete the programme was not uncommon. Evaluations have noted the ‘fragility’ of contact between CMP practitioners and clients (Corden and Nice 2006), and our interviewees raised similar concerns.

Where clients had struggled to progress through the CMP, practitioners diagnosed a number of problems. In some cases CBT-based approaches were not a good ‘fit’ for the client (see above) or literacy problems threw up additional barriers (‘five areas’ CBT approaches have traditionally relied heavily on written workbook materials, although CMP practitioners had developed strategies to assist those clients who were not comfortable with this format). In the districts where group work (as opposed to one-to-one interventions) was the primary means of engaging with clients, some practitioners also expressed concerns that the group format could act as a barrier to less confident clients (see also Dixon *et al.* 2007). Practitioners were also often faced with clients who were too ill to be assisted by the CMP – the complexity of health problems has similarly been cited by prospective CMP clients who have been unable to pursue or complete the programme (Warrender *et al.* 2009). While clients reporting more severe illnesses still often wanted to progress towards work-focused activity, it was acknowledged that there was a need for longer-term, more intensive health interventions for these people. At a basic level, the need for strengthened referral routes to more intensive counselling services was consistently raised by practitioners in a number of different study districts. Finally, there was an awareness that ‘things outside health’ were often the greatest barrier to progression for CMP clients. Progress was often undermined due to problems around clients’ caring roles, household/family problems, debt and poverty issues.

It depends where the client is at for a variety of reasons ... if a client maybe has significant external factors and things like debt, you cannot affect change with that using CBT. What you’re trying to do with CBT is challenge their thoughts, and it’s not an incorrect thought that ‘I could be evicted because I am in debt’ or ‘my son’s in jail’. The main concern at these points is to get the clients involved with services trying to address some of these issues and then come back to us. (CMP Team Leader, occupational therapy background, urban area, Scotland)

In terms of weaknesses in partnering, while most interviewees reported positive experiences of joint-working, a consistent frustration related to the way that Personal Capability Assessments (now replaced by Work Capability Assessments) were operated by Jobcentre Plus. Practitioners reported that on a number of occasions delays in the completion of Personal Capability Assessments meant that clients who

had made some progress under the CMP had their claim for IB terminated (having been assessed by Jobcentre Plus-contracted medics as capable of work). The disruption caused by the loss of IBs, financial problems as a result of being forced to claim JSA at a lower rate, the new pressures associated with the job-seeking demands of the JSA regime, and clients' disillusionment at having been in effect 'punished' for making progress all contributed to high non-completion rates among those who had 'failed' a Personal Capability Assessment (see also Corden and Nice 2006, Lindsay *et al.* 2007). The new ESA regime involves a more employability-focused medical capability assessment that it is committed to delivering earlier results, but our research highlights the need for an assessment system that complements the CMP process.

If a person is on Incapacity Benefit and then they go for the PCA ... and suddenly they're on Jobseeker's Allowance, then it completely changes the whole focus and the whole ethos of what it is that you're trying to do with that client, because suddenly they now are deemed fit for work and they have to be actively looking for work, whereas prior to that the focus was quite different. So I think that's a bit of an area of conflict. (Senior CMP practitioner, general nursing background, urban area, Scotland)

As noted above, in one of our study districts, day-to-day partnership-working between Jobcentre Plus and NHS staff had proved problematic, but for the vast majority of CMP practitioners the relationship with their Jobcentre Plus counterparts was seen as positive and productive. Early problems with inappropriate referrals and a lack of detailed knowledge about the CMP among Jobcentre Plus advisers appear to have been addressed through information and practice-sharing activities that have improved advisers' confidence and raised awareness of the aims and content of the programme (Dixon *et al.* 2007). However, CMP practitioners pointed to high turnover rates among Jobcentre Plus staff as complicating partnership-working. Furthermore, in some cases there remained concerns about variable and/or relatively low referral rates. Nice *et al.* (2009) note that Jobcentre Plus advisers generally appear to have a higher level of awareness of contracted-out options than of NHS-provided services (perhaps partly due to the additional administrative requirements around referrals to contracted-out provision). More generally, as we have noted above, the CMP remains a relatively rarely-used option in all PtW districts, and is often seen as appropriate for those further from the labour market (Bailey *et al.* 2007); and as a means of achieving soft outcomes (for example, perceived improvements in self-efficacy and health) for those still some way from progressing into work (Nice 2009). As PtW increasingly engages with the stock of IB claimants then a 'harder-to-reach' group may increasingly dominate the overall client group and it is likely that CMP provision will have a greater role to play.

A final area of concern relates to the lack of robust feedback mechanisms on clients' long-term outcomes. Weaknesses in monitoring and reporting back clients' progress have been consistently reported in evaluations of the role of the CMP (Barnes and Hudson 2006) and were often raised by interviewees. While the relative lack of tracking bureaucracy (compared to that surrounding contracted-out DWP-funded provision) can be viewed as welcome, access to even the most basic Jobcentre Plus client data – for example on which, if any, benefits clients were claiming following CMP completion – was variable across districts. Many CMP practitioners said that they would welcome more consistent and detailed progression data on the clients. Among senior practitioners and managers there was concern that the

evidence base on the relative impact of their services was weak and inconsistent, with potential implications for the renewal of NHS-led services following the conclusion of existing arrangements in 2010.

Discussion and conclusions

The central issues addressed by all the articles in this special issue relate to appropriateness of current policy responses to reducing the numbers claiming IBs, and how services can be most effectively and efficiently delivered. This article has drawn on existing evaluation evidence and new interviews to explore one policy response (condition management services) and a specific, and in the current climate somewhat unusual, model of governance (a partnership-based approach linking public-sector organisations). Our research adds to the evidence that condition management may have an important role to play in helping people claiming IBs to progress towards work. Evidence presented in this special issue and elsewhere (Beatty *et al.* 2008) demonstrates the fallacy of the idea that there are large numbers of people claiming IBs who are ‘faking’ health problems. The reality is that many claimants face complex health *and* employability-related barriers to work. The fact that CMP services (delivered by both the NHS and contracted providers) have been somewhat under-used under PtW thus far can be put down to the manner in which the majority of clients participate only in work-focused interviews (the only element of PtW that is compulsory and a relatively cheap option for moving the most able towards work). However, the ESA reform process will see an expanded work-related activity group of clients required to undertake some form of activation, while policy-makers are increasingly seeking to target the stock of existing (sometimes long-term) claimants – in short, condition management will inevitably become more important as PtW increasingly seeks to address the needs of a more disadvantaged client group.

How can CMPs be best organised and managed within this context? New forms of multi-agency governance have emerged as key to the management and delivery of employability programmes that are increasingly required to address the complex problems of severely disadvantaged client groups. British policy makers have emphasised contracting-out, often to for-profit private providers, as a favoured means of delivering such programmes, including under the IB reform agenda. Government has advocated this approach as a means of gaining efficiencies but also introducing greater choice for clients. Yet there is evidence that promoting a genuine sense of choice for clients through contracting-out has proved problematic in Great Britain and elsewhere (Wright 2008); and in terms of the current direction of British governance arrangements, the Freud Review’s mechanistic discussion of which agencies should ‘retain ownership of claimants as they pass through the system’ (Freud 2007, p. 6, emphasis added) hardly inspires confidence that future approaches under contracting-out will be designed to maximise the sense of ownership enjoyed by individuals.

Our research highlights that there may be effective alternatives to contracting-out. We have seen how a public-sector partnership between Jobcentre Plus and NHS organisations in the delivery of CMP provision has apparently promoted co-operation and practice-sharing; minimised bureaucratic hand-offs; delivered flexibility in how staff and resources are managed; facilitated dynamism and creativity in the work of individual professionals; and, crucially, allowed for the

inclusion of a major public-sector organisation (the NHS) which brings a unique level of credibility, clinical expertise and customer recognition to *this specific area* of employability intervention. The absence of payment-by-results contracting allowed professionals to focus on addressing the needs of individuals rather than pursuing job-entry targets. Echoing other studies, we conclude that such standardised approaches to contracting would not have been able to involve NHS stakeholders in the same way (Lindsay *et al.* 2008), and indeed in the vast majority of districts where contracted providers lead PtW there is no role for the NHS.

Of course, it is important to reiterate that these findings do not lead us to the conclusion that only the NHS, or only NHS professionals, should be involved in the delivery of CMPs. Our research focused on the experiences of NHS stakeholders involved in PtW. The views of Jobcentre Plus staff and other professionals on partnership-working, and the outcomes reported by clients following participation, would be necessary to provide a more complete picture of CMP partnerships and their efficacy. It is also important that future evaluations seek to capture how different forms of governance influence clients' experiences of condition management services. At any rate, NHS managers and staff were open to the idea of any organisation that could add value participating in programme delivery. There are also cases where NHS professionals acting as CMP practitioners have been ably assisted by non-clinicians trained in the principles of the CMP approach. However, our research adds to the evidence that the organisational capacity of the NHS and the depth of knowledge held by its professionals add value, and should therefore have some role in the future development of CMP provision under initiatives like PtW. For the time being, there remain important challenges for those involved in NHS-led CMP services. NHS professionals participating in our research were well aware of the limitations of a CMP that is unable to assist those with some complex health problems, and the need to offer alternative therapeutic options for those unsuited to a model that, while flexible, relies on a core of CBT-based approaches. It should also be noted that CMPs continue to focus on helping the individual to change – to fit with the labour market – while in-work support and policies to promote healthy working lives remain under-developed (as are initiatives acknowledging the role of inadequate/inappropriate demand in explaining the 'IB problem').

Furthermore, while our interviewees reported that partnership-working with both Jobcentre Plus and other NHS organisations was generally adequate, there were occasional examples of poor communication with Jobcentre advisers. We also identified a lack of consistent information-sharing on clients' progress and eventual outcomes as a major weakness of Jobcentre Plus–NHS partnership-working. If NHS involvement in CMP provision is to be protected, managers and clinicians need to ensure that they build a strong evidence base to demonstrate the added value associated with this form of partnership-working.

Entwistle and Martin (2005) consider the value of a potential re-engagement with partnership-working in the delivery of public services (as an alternative, or just a complement, to the dominant forms of contracting-out favoured by British policy makers). They argue that partnership-working can engender trust and reduce conflict in relational exchange, so that inter-agency collaboration is characterised by long-term commitments, a shared understanding of mutual goals and open access to relevant information, rather than short-term relationships based on unequal access

to information and power. For Entwistle and Martin, partnership-working has the potential to access the distinctive competencies contained within different sectors, with participants involved on the basis that they can add value, rather than their effectiveness in responding to market disciplines and contractual processes. The current and future British governments face the challenge of rising unemployment and a continuing commitment to reducing the numbers claiming IBs. There is room for a wide range of stakeholders in addressing these challenges. However, as the IB reform agenda re-focuses on the long-term stock of clients and a larger, more complex, new 'work-related activity' group, then combining health and employability interventions will play an increasingly important role. There is also scope for a range of different approaches to the governance of employability/health services under interventions such as PtW. But standardised approaches to contracting-out, and the Work First interventions that they often seem to inspire, may not be appropriate for structuring programmes that will inevitably need to draw in clinical and other expertise from a range of sources, and which will be required to assist people with complex problems to make gradual progress towards work. Policy-makers need to be open to the potential added value associated with flexible, partnership-based forms of governance – and the role of public-sector actors as well as for-profit providers – if they are to arrive at effective approaches to promoting employability and health.

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Notes

1. Throughout this article 'IB' and 'IBs' are used as generic terms to cover the previous main incapacity benefits – Incapacity Benefit, Income Support and Severe Disablement Allowance – and the new Employment and Support Allowance introduced from 2008.
2. CBT-related techniques focus on 'bio-psycho-social' approaches to behaviour modification (that is, acknowledging that behaviour is often a product of biological/medical, psychological and social factors). CBT uses a combination of cognitive and behavioural techniques to challenge harmful attitudes and behaviours, empowering the individual to overcome negative self-image and dysfunctional behaviour (Frogatt 2006). It aims to reduce anxiety by teaching the individual how to identify, evaluate, control and modify their negative thoughts and related behaviours (Hawton *et al.* 1988).
3. Private welfare to work schemes failing, *Financial Times*, 29 January 2009. Available from: http://www.ft.com/cms/s/0/2400142a-ee70-11dd-b791-0000779fd2ac.html?nclick_check=1 [Accessed 2 June 2009]
4. The HAD (Hospital Anxiety and Depression) Scale is an extensively-used screening questionnaire designed to capture individuals' immediate reaction to 14 questions, providing measures of anxiety and depression.

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