Abstract

Introduction

The Condition Management Programme was part of New Labour's welfare reform agenda, creating an occupational therapy led service to support Incapacity Benefit claimants to return to productive roles. This paper examines occupational therapists' use of discretion within the Programme, and its effect on their professional identity.

Method

In-depth face-to-face interviews were undertaken with 13 staff employed by the Condition Management Programme, the majority of whom were occupational therapists (n = 8). Interview transcripts were analysed thematically using Atlas ti. 6 as a data management tool.

Findings

Within CMP, managers had a large amount of freedom in service design, creating a service underpinned by occupational therapy. Whilst some decisions were made as part of a multi-disciplinary team, staff were allowed considerable clinical autonomy in delivering the service. The impact on professional identity is discussed.

Conclusion

By underpinning the CMP service, occupational therapists were allowed considerable freedom. Combined with low case loads, occupational therapy appeared to flourish within the CMP. There is a need for further research within mainstream NHS services to examine how discretion affects professional identity.

Key Words

Pathways to Work; clinical autonomy; Incapacity Benefit

Introduction

The research reported in this paper examined the implementation of a back to work programme for Incapacity Benefit (IB) claimants, the Condition Management Programme (CMP), which was rolled out across the UK as part of the Welfare Reform Act 2007. The programme was part of a wider policy to activate IB claimants, Pathways to Work, and, unlike other components of the programme, was largely delivered by occupational therapists (see DWP 2002 for more details of the policy context). The primary stated rationale of Pathways to Work was to empower IB claimants to self-manage their health conditions, increase their confidence and to return to a productive role (DWP 2002:30), and was explicitly targeted at the three major health conditions resulting in IB claims: minor mental health, musculo-skeletal and cardio-respiratory. This focus on productive activity as central to well being is a central part of the definition of occupational therapy (College of Occupational Therapists 2009). Jobcentre Plus Personal Advisors performed a triage function as part of mandatory 'Work Focused Interviews' for new IB claimants. During such interviews, Advisors could refer claimants to a variety of initiatives on a 'menu of choices'. One of these initiatives was the Condition Management Programme, funded by the Department for Work and Pensions (DWP), but provided largely by the NHS in Wales, although across the UK a 40% NHS/60% private sector divide occurred. In providing this service, Lindsay and Dutton (2012) found that NHS staff were extremely flexible to the needs of Jobcentre Plus and the DWP whilst still retaining high levels of clinical autonomy. The CMP was disbanded in 2010, as part of a wider rejection of New Labour back to work programmes. However, in the absence of a body of literature on the use of discretion by occupational therapists, the reported research contains valuable lessons which can be translated into occupational therapy practice.

Literature review

Occupational Therapists' professional identity

The professional identity of occupational therapists can be viewed as less strongly defined than some other professions (Fortune 2000; Watson 2006; Mackey 2007). This has been attributed to the lack of a shared understanding of the 'history, purpose and nature of their role', as evidenced by competing definitions of the role over time (Fortune 2000:225), the absence of a shared belief system (Kinn and Aas 2009), working as part of multi-disciplinary teams (Mackey 2007), a variation in the discipline internationally (Watson 2006) and stronger managerial controls in recent years (Lloyd et al. 2004). Therefore, Fortune (2000: 226) concludes that occupational therapy is a discipline in a state of change, literally an 'epistemological crisis', and thus a common group identity of occupational therapists may not exist.

Despite this, Kinn and Aas's (2009) research found that occupational therapists believed that they had skills that other health care professionals did not, and valued their contribution to a multi-disciplinary team highly, although they felt under-valued by other professionals. However, this may be seen as an attempt to create an acceptable narrative of self (Giddens 1991): in the absence of a strong group identity, occupational therapists may use their own moral values more strongly to create a professional identity (Watson 2006).

Whilst the research evidence highlights the potential for a weak professional identity within occupational therapy, CMP can be seen as an example of an occupational therapy led health-service, where other health care professionals performed a secondary role (Rose, 2008). Furthermore, within this role, clinicians were allowed a high level of clinical discretion and autonomy from

managerial structures, enabling them to draw on their skills and knowledge (Lindsay and Dutton, 2012) resulting in a flourishing professional identity (Mackey, 2007).

Occupational Therapists' use of professional discretion

There is a dearth of literature on occupational therapists' use of discretion and a limited evidence base in relation to health care professionals more generally (Exworthy and Frosini 2008). As a result of this gap, the issue of clinical autonomy will be considered in relation to nurses and inferences will be made in relation to occupational therapists. This is appropriate as both are health-care professionals who are required to study for a degree and register with a professional body in order to be a 'qualified' clinician, and similarities between the two roles have been long acknowledged (see for example Grove, 1988). Research on nurses' use of discretion has found that the extent to which policies and procedures are adhered to is dependent upon a number of factors including: the clarity of guidance and existing local practice (Bergen 2005); the need to meet institutional objectives and the (in)adequacy of resources (Exworthy and Frosini 2008); and nurses' own belief about what is the most suitable way of supporting patients' needs (Wells 1997). The concept of not adhering to a policy because it did not fit with a nurse's sense of the best course of action for a patient is described by Provis and Stack (2004: 5) as a 'dimension of ethical obligation', which can be influenced by individual circumstances and nurses' personal relationships with patients.

In recent years, the role of nursing has become increasingly professionalised resulting in additional prescribing powers and the introduction of consultant nurses. Moreover, the expertise of nurses' clinical judgement has been recognised in predicting risk alongside, or instead of, risk assessment tools (Healey 2010; Fletcher et al. 2010). Alongside this, however, managerial changes have resulted in a reduction in centralised power, accompanied by increased discretion at local managerial level. Consequently, whilst increased powers among the nursing profession may increase both the

strength of professional identity and the use of discretion, managerial changes have constrained this growth in clinical discretion (Hunter 2006).

Whilst occupational therapists are likely to ordinarily face similar constraints to nurses, within the CMP, the constraints were of a different nature. Although the CMP staff were employed by the National Health Service, the programme was funded by the Department for Work and Pensions. Accordingly it was possible that CMP staff could face new challenges to their autonomy, and may need to adopt new strategies to maximise their clinical discretion. In order to facilitate innovative practice, the Memorandum of Understanding upon which CMPs were designed was deliberately loose. The few guidelines dictated that CMP interventions were short term (less than 16 weeks), were targeted at the three most common causes of Incapacity Benefit claims (minor mental health conditions, musculo-skeletal conditions and cardio-respiratory conditions), and were not replicating existing services. Aside from this, CMPs were able to use any methods to support IB claimants to better manage their health condition. It is possible that as an occupational therapy led service with very high opportunities for discretion, occupational therapists could experience a strengthening of their (relatively) weak group identity.

Method

The research reported is part of a larger study of Pathways to Work provided by Jobcentre Plus and the NHS in Wales, although the data reported here relate entirely to one set of in-depth interviews which were conducted to answer the specific research questions documented in this paper. The overarching research question during the field work phase was ‘What discretion do CMP staff have within *Pathways to Work*?’ This was accompanied by: ‘Why, when and how do they choose to use this discretion? And ‘What impact does the use of discretion have on professional identity?’

Following initial discussions with the (non-clinical) managers of two CMP programmes in Wales, a research protocol was written and approved by the Wales Multi-Centre Research Ethics Committee (reference number: 08/MRE09/28).

Participants and data collection

Much of the literature on sampling assumes that the researcher will have a large degree of control over who is selected to participate in their research. In the case of CMP 1 this did not occur. In discussion with the manager of the programme, I described the purposive sample that I desired, and the manager selected the people they thought would be most 'useful' to participate. This resulted in a sample that was representative of the programme's staff in terms of their clinical background and included all senior staff. Such deviations from expected norms during research are now widely acknowledged (see, for example, Coffey 1999), and can be seen as part of the process of undertaking research where access arrangements are precarious. The identified staff were then introduced to the author and were asked to participate in an interview at a later date.

Within CMP 2, all staff members attended a routine staff meeting at which they were told by the author about the research project and had the opportunity to ask questions. Staff members were then given the opportunity to nominate themselves to participate, in person, by email or telephone. A purposive sample was selected which reflected the range of clinical staff, and mirrored the sample in CMP 1. All CMP staff were interviewed in private rooms at the head office of their CMP between June and August 2008. Following a review of existing literature on CMPs, occupational rehabilitation and discretion, an interview topic guide was created (see table 1).

[INSERT Table 1: Interview topic guide]

Interviews varied in length from 40 minutes to slightly over an hour and were digitally recorded and fully transcribed. Transcripts were initially coded by hand to identify key themes, before being uploaded to Atlas ti. 6 for further thematic analysis. In order to ensure anonymity in a small community of health professionals, staff were provided with pseudonyms, with female names being allocated to all staff regardless of their gender. Furthermore, the geographical area which the programmes worked in will not be disclosed.

In total 13 staff took part in in-depth face-to-face interviews; six from one CMP and seven from the second CMP. Participants included the two non-clinical programme managers; eight occupational therapists (two clinical leads; four occupational therapists and two occupational therapy assistants); two physiotherapists and one nurse. The staff of the CMPs had a wide variety of clinical experience, which can be seen in table 2. Although the paper focuses upon occupational therapists in the main, data from other CMP staff who participated will be included where relevant.

[INSERT Table 2: Clinical experience of CMP staff.]

Data analysis

Initially, the transcribed accounts of interviews were coded by hand for key themes. Themes included discretion, interventions and difficulties in implementing CMP. In order to facilitate a thorough analysis of the data, Miles and Huberman's (1994) three stage strategy for analysing qualitative data was adopted, and this was facilitated by the use of Atlas ti. 6 as a data management tool. The Miles and Huberman (1994) approach advocated viewing data analysis as three inter-

related stages; data reduction, data display and conclusion drawing. Having fully coded the transcripts within Atlas ti. 6, data that was not relevant to the research questions was 'removed' from further analysis by printing full lists of coded data from Atlas ti. 6 and placing quotations into tables in order to perform 'data display'. Finally, conclusions were drawn.

Following the early stages of analysis, findings were reported back to one of the CMPs, and staff agreed that the findings were broadly consistent with their experiences. As a result of the rapid nature of the disbanding of the Programmes following a revue in 2010, it was not possible to undertake further planned work with one of the CMPs to ensure knowledge transfer.

Results/findings

The findings presented will map the ways in which occupational therapists and other CMP staff used discretion within their roles, by adopting a process orientated approach to the data. Firstly, the managers' use of discretion in establishing the CMPs will be discussed. This will be followed by a description of the way in which autonomy was utilised by clinicians during initial assessments and in deciding if claimants should be accepted on to the service. The paper proceeds by examining the interventions delivered by individual Programme staff, including discussion of the relative content of work within interventions. The role of professional identity will be related to these events throughout the findings.

Setting up the CMPs: the mangers' perspectives

Interviews with the two CMP managers showed that when they came into post to manage the CMP, the opportunities for discretion within CMP were vast, with the only conditions for developing the service contained in a very broad 'memorandum of understanding'.

> (There were n)o service precedents to learn from, no existing resources to transfer from, so that was enormously challenging in terms of… just the practicalities; the who? What? When? Where? How? So we had to do quite a lot in terms of work on looking at the skills and competencies we would require to deliver the service, the working model we would use to deliver the service… (Lisa)

The manager from area 2, Charlotte, also noted that there was little guidance in how to run a CMP, describing the programme she was appointed to as 'an open book'. Despite the significant challenge described in establishing the service, both managers described their suitability to manage the service. Whilst Lisa focused upon her expertise as a manger within the NHS, Charlotte described her hard working nature at considerable length, with some reference to her previous role as a very senior public sector manager. It was clear, however, that Charlotte recruited a highly experienced occupational therapist, Jessica, to provide expertise that was outside of her competence.

Within the DWP guidance, no one group of clinicians was favoured over another to deliver the programme, although approximately half of the staff in the seven UK pilot projects were occupational therapists (Ford and Plowright, 2008). Both CMP managers – with the support of steering groups - decided to recruit a staff that was led by and overwhelming was made up of occupational therapists, with occupational therapists 'underpin(ing) the service', because their training was viewed as highly relevant to 'improving function' (Lisa) (Lindsay and Dutton 2012).

Moreover, throughout interviews with both managers and clinical leads, the professional influence of the clinical leads was highly apparent.

Referral and Initial assessments

Claimants were referred to the CMP via Jobcentre Plus personal advisors. Advisors completed a four page form, providing some details of why the client was being referred, although Jessica stated that this information was often not clinically accurate and that inappropriate claimants were often referred: 'you have to remember they are not health professionals, they are jobcentre staff...', highlighting the tension apparent when non-medically trained staff are asked to refer claimants to a service delivered by clinicians, and Jessica's belief in the expertise within health care professions. In addition to this, several clinicians stated that it was essential, for service quality and claimant safety, that in the future CMP continued to be delivered by clinically trained staff. They cited their previous experience in NHS mainstream services and their degree level training as preparing them for the role, and that they were 'expert' in knowing how to support this hard to reach group of claimants.

In addition to inappropriate referrals from Jobcentre Plus advisors, Rachel found it frustrating that local doctors who tried to refer patients to the team were unable to do so as a result of the nature of the funding arrangements. As a result of the positive view of the service among local health professionals, the CMP was receiving one or two requests from doctors each week to take on their clients, which they had to divert to the Jobcentre Plus offices. It was believed that claimants' negative perceptions of Jobcentre Plus would then prevent them from self-referring. Denying service to vulnerable claimants, who she believed could benefit from her expertise, was an uncomfortable experience for Rachel.

Within both CMPs, all initial assessments were conducted by occupational therapists, as the programme managers and clinical leads identified them as the most suitable members of staff to be conducting interviews. Furthermore, both physiotherapists who participated in the research acknowledged the desirability for occupational therapists to perform initial assessments, as a result of their broader, more appropriate, skill set. The high status afforded to occupational therapists by Programme managers and physiotherapists, as attested by their majority share of the multi-disciplinary team and their role in triaging new claimants, can be hypothesised as a way in which the professional identity of occupational therapists involved should be strengthened (Fortune 2000).

Following referral, claimants had an individual assessment with a clinician within five working days. Assessments usually lasted an hour, although occupational therapists were able to asses a claimant for a second time to gather further information if they felt it was necessary. Several occupational therapists described how the assessment could be an emotional and powerful experience for participants, as it was sometimes the first time they had been given the opportunity to be able to talk about their health conditions and how they felt about them. Furthermore, staff saw being able to have an hour with each client and (in comparison to work in mainstream NHS services) low patient loads as providing an environment in which to be able to provide a high-quality service to claimants.

The suitability of claimants as CMP participants

Following the initial assessment, within both CMPs, a multi-disciplinary team meeting occurred on a weekly basis in order to decide which claimants should be accepted onto the programme. These meetings were discussed at length during interviews. All staff agreed that the decision of whether to accept a client was taken by the team, rather than individual clinicians. Jessica stated that this was in order to protect staff: ‘the practitioner doesn’t have to take responsibility for that decision

alone...'. Whilst this can be seen as a constraint upon individuals' discretion, members of the teams valued this safeguard and respected the views of their peers. This is in contrast to some of the constraints placed upon the service by the Department for Work and Pensions, which were viewed as illogical and unhelpful.

During the meeting, the occupational therapist who had undertaken the initial assessment would present the claimant's history and a debate about the suitability of CMP for the claimant would follow. These discussions could be lengthy (Jessica, Michelle) as 'individuals are allowed to challenge and question' (Rhian) and could occasionally become heated, when a clinician felt strongly that a claimant would benefit from participation in the CMP despite them not falling comfortably within the service's remit (Grace). Participants identified a wide range of factors that would make CMP unsuitable for a claimant: ill health or severe mental health conditions that could not be well managed within the confines of CMP (Rachel); undergoing interventions or treatment elsewhere (Sophie); having difficult home circumstances (Michelle); being pregnant (Lisa); and lacking in motivation (all) or being unprepared to leave the 'sick role' (Sophie).

For claimants who were defined as outside of the CMP's remit, signposting to more appropriate services, such as their GP or the expert patient programme, or a referral to the local community health team or physiotherapy services, would occur. It is interesting to note that several clinical staff spoke of claimants' 'right' to participate in CMP, regardless of their potential, or intention, to return to work. Thus if CMP was likely to be the most appropriate service to support a claimant, including to improve their 'quality of life' (Jessica), they would be accepted. This shows a belief in the ethos of the National Health Service, for whom all of the occupational therapists had previously worked, which was at odds with the rationale for CMP; there was no 'right' to 'treatment'.

Interventions offered

Following the discussion of whether to accept a claimant onto the service or not, a 'care plan', or 'treatment plan' would be drawn up. These terms were used interchangeably by staff, despite the fact that CMP was explicitly not allowed to provide 'treatment' and shows that despite a difference in the aims of the service compared to mainstream NHS services, the language did not always reflect this. Interventions included 'core modules' such as pain management, relaxation and anxiety management. In both CMPs, if demand was sufficient and it was seen as clinically beneficial for claimants, a group would be run. Staff insisted this was a clinical decision and not a way to save money or see more claimants (Megan), and if there was a reason, claimants would always be seen on a one-to-one basis.

Intervention sessions did not follow a prescribed format, and staff were able to tailor the intervention in response to claimants' conditions and goals, both of which could change over the course of their participation in the programme. The flexibility afforded to staff was viewed nonchalantly, as something that they expected to be automatically afforded as a result of their professional status and previous roles where they had been treated as autonomous clinicians. Furthermore, the ability to provide a bespoke service was highlighted by several members of staff as a crucial part of enabling the service to be successful. Challenging cases, such as claimant's dependence on the service, were discussed on an ad hoc basis with colleagues and senior programme staff, and could also be discussed as part of the multi-disciplinary team meetings.

There was no explicit need within the memorandum of understanding for CMP interventions to focus explicitly on work. As such, it was unsurprising to find two opposing views on the subject. Rhian stated 'I think it's very important' not to have a strong work focus within CMP unless it was appropriate to that participant. However, Grace stated that: 'I can go on about sleep and anxiety all

day, but ultimately for me it's about them having a fulfilling day…that's keeping the work focus…'. Furthermore, Hannah described how the focus on work should be explicit, including groups where CV writing and interview preparation occurred, regardless of if these services were already delivered by an alternative provider. However, Lisa, her manager, was more cautious about 'stepping on toes', in relation to Jobcentre Plus, who were also funded by the Department for Work and Pensions. Regardless of the individual's stance on work, it was clear that many staff valued the freedom of working within CMP, including the *opportunity* to focus on work within the Programme if desired. This was contrasted with mainstream NHS services, where there was not always time to 'focus on the occupational side of it' (Sophie).

In addition to providing advice on current conditions and symptoms, CMP staff were often proactive in advising behaviour change that would prevent a condition from worsening in the future. Moreover, Rachel stated that on one occasion she had supported an entire family by using 'family therapy' within CMP. It was suggested by Sophie that working for the CMP allowed 'a bit more freedom' than mainstream services. On the other hand, many staff noticed their discretion being undermined by the necessity for CMP to be non-treatment based. This resulted in some clinicians not utilising clinical skills that they believed could have supported a client alongside other CMP interventions, and was a particular issue for physiotherapists and nurses. Furthermore, the need to discharge claimants within 16 weeks was seen as insulting to Grace's professional identity:

> 'I'm a highly qualified, very experienced, trained clinician. I should be able to make those decisions regarding whether somebody should be discharged rather than the Government...'

Discussion and implications

Throughout previous research into CMPs, elements of professional discretion could be identified (see for example, Lindsay and Dutton 2010, 2012). This, however, had not been extended to an analysis of how such discretion impacts upon professional identity. The literature on occupational therapy and discretion identified that the discipline did not have a clear, defined role that differentiated strongly from other health care professions. However, within both research sites, the multi-disciplinary service was underpinned by experienced occupational therapists and founded upon models utilised within occupational therapy. Moreover, the service was intrinsically about improving function and returning service users to a productive role. This can be viewed as a service in which the very ethos of occupational therapy, and occupational therapists, flourished. As a result of the political attention focused on IB claimants, Department for Work and Pensions funding provided healthy budgets, allowing staff to hold low case loads compared to mainstream services and considerable flexibility within service design and implementation. This, however, should be seen within the context of having a staff of highly experienced (7-27 years) occupational therapists, and it is possible that less experienced occupational therapists may have struggled with such high levels of autonomy (Barnes and Hudson, 2006). Furthermore, small tensions existed when the memorandum of understanding imposed conditions upon the occupational therapists' discretion, in relation to not providing 'treatment' and discharging claimants within particular timescales. Whilst the CMPs have now been disbanded, this paper provides a rare insight into occupational therapists' use of discretion.

The occupational therapists in this study identified that their roles were very different to mainstream NHS occupational therapy roles, and consequently the findings of this study should not be generalised to other roles that occupational therapists are engaged in. As such, the strength of occupational therapy within the CMPs should not be used as evidence to refute Fortune's (2000)

assertion that occupational therapy is facing a crisis regarding its professional identity. In order to gain a wider understanding of the use of discretion and its impacts on professional identity of occupational therapists, it is necessary for larger scale work, both to be conducted within a mainstream environment. This could include a randomised control trial in which some occupational therapists are given additional discretion in their work in order to encourage innovation (based upon evidence, or in order to contribute to the evidence base) within service design.

Conclusions

New Labour's Pathways to Work policy introduced a variety of 'choices' for IB claimants, in order to facilitate a return to work. The most novel of these was the CMP. In both research sites, the CMP was provided by the NHS, and was largely staffed by occupational therapists. Previous research had argued that occupational therapy was a discipline with a less strongly defined collective professional identity compared to other health care professions. As evidence suggested that this was to do with a lack of a strong professional role, it was anticipated that working within a team underpinned by occupational therapists and with a strong focus on occupational rehabilitation, professional identity should be strong.

The data presented in this paper examined the views and experiences of 13 CMP staff, of whom 8 were occupational therapists. The occupational therapists had a large amount of clinical experience, and it was clear that all reported that they felt qualified to work in their current role. Within the CMP, opportunities for occupational therapists to use discretion were extremely wide, and staff responded well to this. Autonomy was controlled in two ways: via management and clinical leads, including the decision to accept or reject claimants being made by the entire team, and via the

Memorandum of Understanding with the Department for Work and Pensions. In practice, both constraints were policed by managers and clinical leads, but challenges to autonomy that were introduced by the CMP management team were seen as helpful and in the clinicians' best interests. On the other hand, the confines imposed by the DWP were resented for their lack of clinical reasoning.

In general, occupational therapy could be seen as flourishing within the CMP, and the freedom within the Programme was directly contrasted by many members of staff with mainstream NHS practices. In order to adequately assess the strength of occupational therapists' professional identity and use of discretion, it is necessary for larger scale research to be carried out, and this should occur within mainstream services, where the majority of occupational therapists are employed.

Key findings

Within the context of *Pathways to Work*, Occupational Therapists:

- Led the multi-disciplinary team
- Were able to act with considerable discretion
- Had a strong professional identity

What the study has added

The study provides qualitative evidence of how occupational therapists used discretion within an atypical NHS programme and the impact of this on their professional identity.

Conflicts of interest

None

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