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Committee for Employment and Learning

OFFICIAL REPORT
(Hansard)

Condition Management Programme: Western Health and Social Care Trust

23 May 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Basil McCrea (Chairperson)
Mr Thomas Buchanan (Deputy Chairperson)
Mr Jim Allister
Mr Sammy Douglas
Ms Michelle Gildernew
Mr David McIlveen
Mr Pat Ramsey

Witnesses:

Ms Liz Doherty	Western Health and Social Care Trust
Mr Raymond Farrell	Western Health and Social Care Trust
Ms Philomena McManus	

The Deputy Chairperson: You are all welcome to the Committee. We will give you around 10 minutes to make your presentation and then we will open the meeting to members' questions.

Ms Liz Doherty (Western Health and Social Care Trust): Thank you, Chair. We are delighted to be here this morning. It is not often that practitioners who work at the coalface get a chance to come here to address you. We hope to give you an overview of our work in the condition management programme (CMP) in the Western Trust. I am an occupational therapist and team manager based in Londonderry. I am joined by Raymond Farrell, our specialist mental health nurse who works from Enniskillen. We are delighted to have with us Philomena McManus, an employee of the Western Education and Library Board. She is here to tell you about her experience of using our service.

Our short presentation will, I hope, tell you how we operate in the west, what the service offers, and we will then look at the potential direction in which we can move in the future. Our key message is that the earlier health intervention is offered to people, the more likely they are to return to work and get back into sustained employment. I suppose that achieving that is the key driver behind our programme.

I will give some background. We were set up in 2007. At that time, the Department for Employment and Learning was very innovative in commissioning our services from the Health Department. That was a brave venture in buying services from health to address the needs of people who were, at that stage, on incapacity benefit. About two thirds of those people were found to have mild to moderate conditions. With timely help, they could be motivated and moved back into work again.

The types of conditions that emerged were in three main areas. Mental health issues accounted for about 57% of the clientele that we see. We work with people with anxiety and depression that, for many, resulted in stress at work. We also work with people with musculoskeletal problems, such as bad backs, necks and joint pain. Looking around, I see a few candidates here. *[Laughter.]* So you will probably all have been familiar at one stage or other with those. A smaller number of people with cardiac or respiratory conditions come through the programme, as well as those with other conditions.

The programme is unique in that we do not mirror what is offered in the health service. We do not offer hands-on treatment to people; we utilise the skills and experience of healthcare practitioners and their work. We look at how we can educate the person to manage their condition and optimise how they function in the workplace.

We use a bio-psychosocial approach. We look at the effect on people's lives of the biological, psychological and social aspects. We look very much at how education can increase their understanding. Raymond will tell you about how we use the cognitive behavioural therapy (CBT) approach to challenge unhelpful thinking and behaviours. People who are not working and do not have a structured routine also become physically deconditioned, and we look at how to increase their activity levels. We also promote effective coping strategies for pain, lowered mood, and so on. We seek to help clients to develop overall healthier lifestyles, so that people can sustain improvements in their condition and in their work, once back in it. How they cope when they get back to work is one of the key issues. How do they sustain that? If a person's health condition has not gone away, might it flare up again back at work? With timely intervention, people can again seek help or know how to manage their own condition, which will help them stay in work as opposed to coming off again.

We collate employability indicators at the start and end of the programme. Happily, the results are very favourable, particularly those on improving people's attitudes to re-engaging in work, employment or training. Another interesting development is that all CMP teams in Northern Ireland offer their services to Department for Employment and Learning staff who are off sick or struggling to manage their health problems in work. The feedback on that has been extremely positive. I am sure that sickness absence is an issue for everybody in these days of dwindling resources and more pressure on employees. I appreciate that the future of the Department for Employment and Learning is uncertain, but we think that CMP could be offered to other Departments and staff in the future.

I will pass you over to Raymond, who will outline how CMP can help people, particularly those with mental health difficulties.

Mr Raymond Farrell (Western Health and Social Care Trust): Good morning. Thank you very much for the opportunity to be here this morning. It is nice to see some familiar faces. I will reiterate some of what Liz has said. Mental illness costs millions of pounds in respect of people being out of work. I am very grateful for the fact that the Assembly, as a body, has identified that it wants to promote and highlight the issues of mental illness. As a mental health practitioner, I thank you for that. It is a very positive step.

The economic cost of mental illness runs into millions of pounds. It affects individuals, their families, society and our economy. As politicians, that is something that you have to be very concerned about. Work is good for us. That is well known. Research shows that up to 90% of people who sign on for incapacity benefit or employment and support allowance (ESA) want to get back to part-time or full-time work. That is something that we have to take note of.

Being out of work affects a person physically. Long-term unemployment can result in physical health problems, obesity, hypertension and diabetes. Treatments for those problems are putting an added cost burden on the health service. Therefore, the earlier people can get back to work, the better. There are also mental health implications for being out of work. Research shows that being out of work for more than six months increases the risk of suicide, particularly among young males. That is very worrying indeed.

Being out of work has an impact on the individual. They may feel isolated, as they cannot be with the friends that they had in work, and they may not feel part of things. That has very grave repercussions for one's mental health. There is also the social exclusion, which I have highlighted. As a practitioner, I know that that can result in changes in how a person thinks about themselves, how they think about those around them, and how they think about the world in general. That can result in more chronic mental health problems.

Research indicates that a combination of education, confidence building and focus on managing a condition are key to getting people into the workforce or into some form of activity. Therefore, the CMP aims to address health conditions that are less serious — what we term as mild to moderate conditions — to help people better understand their condition, with a view that they will feel more confident to progress into some form of work-based activity.

I am a cognitive behavioural therapist. An old Greek philosopher said that man is not disturbed by things, but by the view he takes of them. That is the premise for a lot of what CBT is about. In cognitive therapy, we work on the basis that thoughts have a big impact on how a person behaves. Therefore, if one has thoughts of depression or hopelessness, it will impact on how they feel, and how one feels affects how one behaves. There is that triad of thoughts, feelings and behaviour, and a linkage between them. That is the basis of what we do.

Cognitive behavioural therapy is recommended by the National Institute for Health and Clinical Excellence (NICE) as a preferred treatment for mental health problems, working with or without medication. It is a very effective talking therapy, and it is strongly pressed by the Royal College of Physicians and the Royal College of Psychiatrists as a form of treatment that is very effective in managing mental health conditions.

In practice, what do we do? Clients are referred to us from an employment adviser in the local jobs and benefits office, and they will have outlined the aims and objectives of the programme. The programme is entirely voluntary. It is important that no one feels forced, because, if you are forced, the impact is lessened. People have to feel safe to make use of the programme and avail themselves of it. We see people and do an assessment at which we ascertain their mental health problem, how it affects them, how it affects their mood, how it affects their behaviour and what they can and cannot do, which is important. Over a 12-week period, it is important that we offer the person the opportunity to become more aware of their condition — be it depression, anxiety or stress — through education. Education is key. People may have heard certain myths. For example, I have met people who have said that if they take tablets for depression and sit in the house, the depression will, hopefully, go away. In the health sector, we know that there is more to it than that, and it is important that we get that message across.

Once we have covered the educational aspect and worked together on that, it is important that we identify new learning. There are questions to be asked, such as: what has the person learned from this? How can we put that new learning into practice? What can we do with what we have learned? We can learn something, but unless we put it into practice, it is largely ineffective. It is important that a person gets the opportunity to do that in an appropriate field.

With new learning, we encourage people to get into opportunities to be more socially interactive, to build up confidence and to, perhaps, volunteer for certain things. The Department for Employment and Learning has some very useful opportunities in relation to Steps to Work, where people get the opportunity to learn and develop themselves in certain areas. That leaves them better skilled and, in turn, that hopefully helps boost confidence even more. That is the nuts and bolts of it.

We work with clients on a one-to-one basis, and we also offer group work. I am not a specialist in the field of pain but, sometimes, people who are experiencing pain have an opportunity to explore together how pain affects them so that they do not feel so isolated. It is the same with depression. You can share your situation with other people, and that leaves you feeling less isolated. That is something that we work on.

We also cross-refer. My background is in mental health. We also have physiotherapists, occupational therapists and exercise professionals. If we feel that we can refer to other people so that they can bring their specific expertise into the field, we do that so that a person has a holistic opportunity to improve and benefit from the programme. At the end of the 12 weeks, we liaise with the employment adviser again and look at other pathways that a person can avail themselves of and develop themselves on.

I am pleased to have Mena with us. She has availed herself of the condition management programme, and she would like the opportunity to tell you what it has done for her.

Ms Philomena McManus: I am from Lisnaskea. I was working really hard. I had been in an abusive marriage, and I got out of it. I bought out my house from my husband, and I had to take on more work to pay the bills. Then, my health gave up, and I took a stroke in September 2010. I was admitted to hospital and kept there for four days. I thought, "My life is over now. I will never be able to do anything again." However, when I got out of hospital I got in with people who were able to show me the way forward, take me under their wing and help me along. Through that, I met Grainne, who was the girl I did the CMP with.

Grainne was my saviour. I was suicidal, and if it had not been for the programme, I would not be here today. I know that because all my self-confidence was gone, and I did not think I would ever be able to do anything again. I have three lovely nieces and I had been involved in so much around the community, but that all fell away for a few months.

Gradually, after a few meetings, I felt a bit better and got back into doing things. I will never have the same energy again, and I will probably never be able to do the 70-odd hours a week that I was doing, but, looking back on that, it was sheer madness doing so much. So, thank God, I am able to be here to tell you about myself.

The stroke has left me with little energy, and tiredness and weakness all the time. Other than that, I have a great mind; I am able to talk to people and help them out when they come to me. When I started the programme, I would have gone in crying, but every day I came out I always felt better. I had to be constantly reminded to pace myself slower to build up my confidence again. My self-esteem was very low, and with Grainne's help I have got that back too. I am really grateful for what I have got and for my life. My life is at a much slower pace, but that is still good.

Now I am able to say no to people. I used to take on so many roles: as well as working all the hours I was, I was helping everybody else out. Now, I can say no to some things. If it had not been for Grainne, I would be saying, "Yes, yes, yes", but now I can say no to some people, which I feel good about.

I am back at work, and I am on permitted hours, which I love. That gets me out of the house and keeps me from going insane. My job is in the school, and it is very physical. Everything is timed there; for example, at 11.00 am you will be doing one thing but at 11.05 am you have to do something else. I am able to cope with that now. It is gets me out of the house and means I am meeting my friends at work, who have been a good support to me. It is lovely to get out. I could not spend seven days a week in the house doing nothing.

I never had heard tell of condition management until I went into the job centre and was referred on. Today, I have a lot more confidence and do not worry about what happened yesterday or what might happen tomorrow: I just live for today, and I am grateful.

I have done an English class since I took sick and have passed a wee exam in that. Now, I am doing maths. I should be at that class today, but Stormont was a better option. It was nice to get away for a day as well. I will probably catch up: I have a good tutor who will give me the notes to take home with me or get them for me next week.

At the condition management sessions, Grainne made relaxation tapes for me. She directed me in the right area of physiotherapy. The stroke had affected my bladder badly, and she was able to get me into physio. She recommended that I ask my doctor for a treatment, which I got. I was able to go to a stroke liaison nurse who guided me through a lot of things. So, with Grainne's expertise, I learned a lot and got a lot of help. She pointed me in the right direction all the time.

I am still receiving some of the treatments. Some day, I might not need the treatment with a bit of luck, but if that does not happen I will have to accept it. My family can see a difference in me. My nieces are up every other day and say, "You look good today." I might take time to put on a wee bit of make-up, whereas I would not have before the programme — just simple things. I am not a big shopper, but when my niece asks me to go to the shop with her to look for an outfit I say of course I will, whereas I would have said no before this. With the management programme I got an awful lot of help from the health board. I had to face a load of doctors. I think I had four medicals in the past year. I never tell a lie, and I think everybody knew there that I was telling the truth, because I was well received and I did not feel under pressure. Before that, with anybody other than a local worker, I would have felt threatened, but today I do not feel that way. That is the confidence that I have got from it.

I did a 10-week or 12-week course, and in all the time that I was with Grainne her dad was terminally ill, but she never let her home life affect my recovery. That is something that I have to admire her for. When I was asked to come here today, I had no hesitation in saying yes, because I think it was a wonderful programme. I do not think enough people can get it. They do not have the time to provide it to so many more people, but there is an opening there, and it should be kept in our local areas. I am only one spoke in the wheel, and it helped me so much that I think it could reach out to far more people if they have the time and resources, so I would love to see it being backed as much as possible.

Ms Doherty: Thank you, Philomena. In summary, hopefully you have got a better idea of what we are about, and Philomena has highlighted that very well in her example. She has also mentioned the commitment and dedication of the staff that we have within CMP. We do have very motivated, experienced staff who are ready and willing to work with people. There is a certain amount of uncertainty among them because the future of our programme is not secure beyond next March.

The change in the benefit system has had a big impact on our programme, because we were initially designed to work with people with mild to moderate conditions and, since the advent of ESA in October 2008, we are finding that the people that we are seeing on the ground are becoming more complex, with more chronic conditions, and they are further away from the workplace than the people whom we were initially set up to target. That is not an issue in itself, because we can work with those people, but, at the moment, we are limited to a 12-week time frame. I think there is opportunity for development of CMP, and possibly different versions of CMP for different clientele. For example, a civil servant who is coming because they are struggling in work may need only a few sessions of CMP. Somebody who has been out of work for 10 years is perhaps going to need longer to move along that work continuum and change their attitude towards work — to help them to overcome the health condition with a view to them being able to get and sustain work in the future.

I think there are opportunities to think about the way CMP might go in the future. It does not just need to be unidirectional, but, at the moment, things are slow to catch up. The system has had a knock-on effect on us, but we are not able to get to some of the people whom we were getting very good work outcomes with before. The key message is that, if health intervention is offered at the earliest stage possible, the return to work is most likely to happen. So that first stage of a benefit claim would be the most opportune time, but, for us, at the moment, that is not always the case. It would be a shame to see such an innovative partnership between the Department for Employment and Learning and the Department of Health fold, given Dame Carol Black's recommendations at the moment that health should be fully integrated into employment and skills training programmes. That is one of the clear recommendations. I hope that you can consider that and take it on board as things develop for the future. Thank you for the opportunity to address the Committee today.

The Deputy Chairperson: Thank you for your presentation. I commend you on the programme that you are running. The success stories that we heard today make it all worthwhile. Before I open up the floor for questions, can I ask you how many people you bring through your programme every year? Are businesses and employers made aware of the programme that you run? Employees could be under stress and might need some guidance to keep them in employment, rather than them getting depressed and getting out of employment? How are they made aware of the programme, and can they avail themselves of it?

Ms L Doherty: Unfortunately, they cannot because the point of entry is through employment advisers in the local jobs and benefits office. The target population is employment and support allowance and incapacity benefit claimants. We have extended it to people who are migrating from incapacity benefit to job seeker's allowance (JSA), but, at the moment, we are not open to mainstream JSA claimants. Therefore, not everyone with health problems can avail themselves of our programme. We are ideally placed to help smaller employers and people in the private sector, and we would like to do that. However, the point of entry to the programme is the issue. It would be much easier to get the person while they are still in work and to look at the functional problems that their condition is imposing on them. That is where our advice and guidance would come in and sustain them before they go off sick. Therefore, if the programme could be widened out, we could offer valuable help to sustain people in employment.

The Deputy Chairperson: What is your success rate for getting people back into employment? I know that we are in a difficult time economically, and jobs are being lost around us, but what is the overall success rate?

Ms L Doherty: We have to bear in mind that it is a 12-week programme, so it is a starting point to moving along the work continuum. However, we have been following people up at six months following the programme, and our results show that, overall, post CMP, 22% of people who have completed the programme are back in full-time or part-time employment, and a further 20% are in training and education — they are upskilling. For example, people with musculoskeletal conditions cannot necessarily always return to the work that they did before, so they may have to upskill to get into a different field of work. Given the current climate, those statistics are not bad, particularly in the geographical patches in which we work. We work in Foyle, Lisnagelvin, Limavady, Strabane, Omagh and Enniskillen. As I am sure you will be well aware, those areas all present challenges.

The Deputy Chairperson: Perhaps it shows again that the west is leading the way.

Mr P Ramsey: Someone else from the west. Good morning. You are all very welcome. I am very interested in your figures, which suggest that 16% have returned to work and a further 15% are in training or education. It is important that those statistics are available and can be tracked, but your principal point is that it is much better to provide intervention when somebody is in work to try to keep them there. Therefore, the figures do not help in that respect, as those people were not in work. I was only vaguely aware of the programme, but it is a fantastic scheme. Philomena, your story is remarkable, really and truly. It is wonderful to see you coming along here, giving a magnificent testimony to what can be done with the proper intervention.

Ms McManus: I cannot recommend it enough.

Mr P Ramsey: You should be very proud of yourself

Ms McManus: I am.

Mr P Ramsey: I am sure that your family is very proud of you as well. You are a marvellous champion for people who have had a stroke. The Stroke Association Northern Ireland should be looking to you to be another champion and advocate for how things can be done right. Never mind the stroke, the occupational therapy that you are getting is easing the mental pressure that you may be under. It is certainly lovely to hear.

Liz was quite right: there was a debate in the Assembly this week about the migration from incapacity benefit. There is no doubt that thousands of people will be affected by welfare reform, so programmes like yours have an immense role to play. This is an example of very joined-up thinking. However, you are right to point out that we need consistency and continuity to achieve a determined effort. That is particularly true in areas of social need, which is clearly where you are involved in targeting social need (TSN). I am interested in getting the breakdown of areas where you are working.

You suggested that, at the moment, the main referrals come from employment advisers, to the extent that those interviewed may have a moderate or mild arthritic problem or mental health issue. However, the situation will arise where increasing numbers of people with more complex needs will need assistance. Is your organisation fit to advise them? For example, in Philomena's case, having a stroke and, given her background, that could not be described as "moderate". Chair, I wonder how we can help this programme.

We have been strongly focused recently on youth unemployment, and rightly so because there are over 40,000 young jobless people in Northern Ireland. It is important that those people, who may be the second generation of families that are culturally dependent on benefits, are encouraged and given the confidence to make the transition to realising that work is the right place for them. Given the tsunami of demand that is coming in the next year with welfare reform, how do you get to that next stage? Are you fit to deal with that demand or can you progress further again?

Ms L Doherty: That is why I suggested that innovation in the delivery of our programme is required, with the changing profile of the people coming through. We need to be creative in how we deal with these people because, as you said, the severity of our clients' conditions will increase. We are already seeing that on the ground. At the minute, the process is tightly bound around that 12-week time frame. I have no doubt that our staff could cope, because they have great skills and expertise from health. That is not the daunting part. If more people are to come through, capacity may be an issue because we have been dealing with only incapacity benefit clientele and had year-on-year projections of the number of referrals that we would get.

I think that different versions of CMP would be the way to go. People who have not been in work for a long time and whose conditions are more chronic may need more help and time to achieve an attitudinal change. For example, one of the key things that we need from people is motivation and willingness to change. I was working with a client in the Foyle patch recently who presented to our programme at 36, not having worked a day since she was 19. I did an information session in our Foyle jobs and benefits office, and she volunteered for the programme. After 12 weeks, there was a big shift in her belief that she could cope with her condition and look to upskill for work in the future.

By the time that she left our programme, we had linked in with her employment adviser and done a CMP exit interview. The following week, she was to join Steps to Work for a 20 hours-a-week placement to work on her essential skills needs. I think that for us to effect that change in somebody who had not worked in virtually 20 years was pretty impressive.

Mr P Ramsey: Clearly, there is evidence that this model is working very effectively and well. I am very keen to hear from the Department on how it wants to progress this, given what is down the line for us with further migration from benefits to availability to work. All I can say is that this is a great project and well done to you all, particularly Philomena.

Ms Gildernew: I do not do this very often, but I am going to commend the Department and the Health Department for putting this programme in place. I have been very impressed by all of your testimonies, especially Mena's. I know how heavy working in a kitchen is, and for somebody who has had a stroke to go back into a kitchen and hawk big pots of spuds and the rest about is commendable. It is not that you were going back to an office job; you were going into a physically demanding environment, which, as you said, is very stressful and time-limited.

You really touched a chord with me today. Over the past 12 months, I have had a couple of really rough patches, and I know how important it is to keep people in work. The Health Committee had done work on early intervention and self-referral to allied health professionals so that somebody in work would not have to wait for a doctor's appointment for a referral to a physio and, instead, knowing that they had a twinge in their back that was getting worse, could go and see a physio and refer themselves. That would hopefully mean not taking the time off work, which would be of benefit not just for economic reasons but, as you pointed out, for mental and emotional reasons. If you are in a job that you enjoy, you are going to be a lot better off in your own self than if you are at home, looking at the four walls.

I have been very impressed by what you have said today and by the fact that somebody had the wit to put the CMP into place. Whoever invited you here, the Committee Clerk or Basil, thank you very much, because it has been very enlightening to hear what you have had to say.

I concur with Pat about the discussions that we need to have with the Department. If the Chairperson will undertake to do so, I recommend writing to the Department, because the exclusion of people on mainstream jobseeker's allowance is a big problem. As Pat and everybody else around this table would flag up, with welfare reform and what is coming down the line, there will be an awful lot of people who need your service. We need to be strengthening it and expanding it as opposed to running it down, so I would be keen to know the future of the programme.

I know too that the lack of employment opportunities in the areas that you work in mean that the figures are not reflective of the success that you have had. We will want to get that point across too to the Employment and Learning Minister. We should also talk to and write to the Health Minister, because this is the kind of work that we have been trying to encourage. Prevention is always better than cure. That is the kind of message that we have been trying to get across to the Health Minister. If this Committee could undertake to write to Edwin Poots as well, it would help to strengthen the arguments that we have been making.

As the level of entry is in job centres, that limits the amount you are able to do, but innovation and forward thinking is needed. This is a spend-to-save project, and that is the type of point that we need to make to ensure that it continues.

Mena, I am sure Grainne will be very pleased when she reads your comments. I am in no doubt that the people who are working in that team are special and are helping people, not only to get back to work but to get back to their lives. So it is a huge thing that you are doing, and I am very impressed.

I do not have any questions. I was going to ask about the numbers, but Pat has already done that. So, well done and please keep up the good work.

Mr D McIlveen: I echo what the others have said. Mena, you in particular are an inspiration. Well done for not allowing yourself to be left on the heap, as such. You have shown real fighting spirit, which is inspiring. I have a question about the Department as a whole and your experience of it. Obviously, your programme is very successful. However, it would be very easy for that good work to be undone if the next part of the process were deficient in any way. Mena mentioned the permitted hours scheme that she is on at the minute. How flexible are DEL's schemes when people move to the next stage? At constituency level, I have had a few queries about permitted hours, and, to the best of my knowledge, there is a limited time frame for that arrangement, and a person can only be on those hours for so long. After that, where do they go?

Somebody with a long-term mental or physical illness will naturally have good days and bad days and good weeks and bad weeks. The flexibility of permitted hours seems to work very well for people, and they can make the best of the time when they are feeling well and feeling up to work. However, other schemes do not have that degree of flexibility. Have you found that to be the case? I am conscious that you do not want to bite one of the hands that feed you, but it would be a travesty if the great work that you are doing is undone because there is not enough flexibility in DEL to support people as they move on in their career path.

Ms L Doherty: There has been a change in provision with respect to the choices offered. CMP is the only health one, but you referred to the permitted work scheme. A number of our CMP clients would progress to that scheme. Rigidity can be limiting sometimes. Some people's optimum level might mean that they can work only two days a week or three mornings a week; and some schemes may not necessarily be tailored to increase as the person goes on, or to look at their optimum level and whether we can maintain them, and whether they are viable for the person from a financial point of view.

Mena used the permitted work scheme, and it ran for a year. She worked two days a week, and, after that year, she had to look at either upping her hours again or reducing to one day a week and looking at benefit income. That is a real example of how flexibility would have meant that Mena could have been working two days a week as opposed to one day.

Mr D McIlveen: A lot of us have encountered that issue at constituency level. People want to work, but they are nearly being penalised for that because of the inflexibility of the schemes.

Ms L Doherty: It is particularly real for people with health problems. They are ultimately concerned that their condition could relapse or flare up, which, in a work environment, is more likely to happen, as opposed to when they are at home and not engaged in activity. There will be apprehension that it might not work out and that they may have to come off benefit.

The Deputy Chairperson: Are you funded by the Department of Health?

Ms L Doherty: We are funded solely by the Department for Employment and Learning. That is how the Department is so innovative.

The Deputy Chairperson: The programme is provided mainly in the Western Health and Social Care Trust area. Is it provided elsewhere?

Ms L Doherty: It is regional. We just happened to be the lucky ones who got to come and address you today. There are very active CMP teams in each trust area across Northern Ireland. The CMP teams service each of the 35 jobs and benefits offices; so, the make-up of the teams is regional.

The Deputy Chairperson: You have a concern about the programme coming to an end by March next year. Why is that happening?

Ms L Doherty: Basically, it is about security of funding. The programme is funded, year on year, in service level agreements with the trusts through the board. At the minute, we have been told that we will be funded until the end of March 2013. Beyond that, there is no certainty for our future. That is as much as I can tell you. That is what we have been told.

The Deputy Chairperson: Thank you very much for coming, for making a presentation and taking our questions. It has given us an insight into the tremendous work that you are doing.