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Supporting claimants' health: A role for the Personal Adviser?

Jenny Ceolta-Smith

**A thesis submitted in partial fulfilment of the requirements of
Sheffield Hallam University
for the degree of Doctor of Philosophy**

September 2014

Abstract

Supporting claimants' health: A role for the Personal Adviser?

This study centres on the way in which welfare claimants' health-related needs are understood and addressed within the new welfare-to-work landscape. The study takes a specific interest in the role of the Personal Adviser, a central frontline practice figure who has previously been extensively involved in implementing UK welfare-to-work policy. A qualitative methodology underpinned by ethnographic principles was implemented. The study design aimed to take into consideration the macro, meso and micro-level factors that characterise the policy arena, provider organisations that provide employment support and frontline practice. The methods selected were: a documentary review, participant observation of the policy arena, observation of the practice arena and semi-structured interviews. The study found that the Personal Adviser is often at the heart of employment support delivery. Personal Advisers are expected to be competent in adopting different roles, some of which might conflict and cause tensions, when meeting the diverse needs of claimants who have health conditions. These findings raise important questions about the legitimacy and preparedness of Personal Advisers' practice in relation to supporting claimants' health. The findings also found that Prime Work Programme provider organisations had proposed varied levels of health-related support provision, and some of their models had a lack of prominence to health. This raises concerns about equity, quality and adequacy of any support being provided. The need for welfare policy to retain a health focus has been shown to be crucial, and integration between the NHS and employment provision needs to be improved, especially at the frontline. This study has contributed new knowledge about the nature of health-related support within the policy and practice context, and the Personal Adviser's role in supporting claimants with health conditions in the newly emerging world of welfare-to-work.

Acknowledgements

My personal development through the completion of this programme of study and writing of this thesis, would not have been possible without the input and contributions of the many people and organisations who have offered their time and support. I would like to thank everyone who has been part of my journey.

In particular, I would like to thank my two supervisors Dr Angela Mary Tod and Dr Sarah Salway, both of whom took a Director of Studies role, for their continued support, expertise and encouragement over the last five years.

I am grateful to the South Yorkshire Collaboration for Leadership and Health Research Collaboration for my sponsorship and opportunity to conduct this study. I have appreciated the support from the team within the Health Inequalities Theme, especially Lerleen Willis. I would also like to thank the team at the Centre for Health and Social Care Research for their ongoing assistance.

My thanks go to the organisations that were open and willing to be involved in this study. To all of the managers and their teams, and clients who gave permission to be observed and interviewed. I would also like to thank Darren Bickerstaff and the South Yorkshire Condition Management Programme for their support and interest in the study.

I am thankful for the many conversations, information sharing and critical feedback given by many colleagues at Sheffield Hallam University, peers and friends. I would especially like to thank Lynn Coulstin, Olga Stepanek, Julie Firth, Sally Bramley, Colette Fegan, Yvonne Channer, Yvonne Cooper. To those who have helped with proofreading, Amber Ceolta, Helen Ford, Jackie Palmer and Dan Woolloff for his patient support in formatting this thesis. Finally, my thanks and appreciation goes to Colin and Conrad Barrow for their endless support which has enabled me to complete this study.

This thesis presents independent research funded by the Health Inequalities Theme within the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care for South Yorkshire (NIHR CLAHRC SY). The views and opinions expressed are those of the authors, and not necessarily those of the NHS, the NIHR or the Department of Health, www.clahrc-sv.nihr.ac.uk

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Abbreviations

A4E-Action for Employment

AMP-Advanced Personnel Management

BPS-British Psychological Society

CBT-Cognitive Behavioural Therapy

CMP-Condition Management Programme

CPA-Contract Package Area

DEA-Disability Employment Advisor

DLA-Disability Living Allowance

DWP-Department for Work and Pensions

ERSA-Employment Related Service Association

ERSC-Economic and Social Research Council

ESA-Employment Support Allowance

GP-General Practitioner

IAPT-Improving Access to Psychological Therapies

IB-Incapacity Benefit

IBPA-Incapacity Benefits Personal Adviser

IEP-Institute of Employability Professionals

IS-Income Support

JCP-Jobcentre Plus

JSA-Jobseeker's Allowance

MSL-Minimum Service Levels

NAO-National Audit Office

NCCHPP-National Collaborating Centre for Healthy Public policy

NCVO-National Council for Voluntary Sector Organisations

NDDP-New Deal for Disabled People

NHS-National Health Service

PCT- Primary Care Trust

PoWER-The Professionalisation of the Welfare Expert Reference Group

PtW-Pathways to Work

WC-Work Choice

WCA-Work Capability Assessment

WFHRA-Work Focused Health Related Assessment

WFI-Work Focused Interview

WRAG-Work Related Activity Group

Terms

Black box- *'The 'black box' refers to the processes used by contractor organisations in delivering welfare-to-work services. Essentially each organisation is free to decide how it does things (i.e. what goes in the 'black box'); nothing is prescribed or ruled out by government'* (Ben-Galim and Sainsbury 2010, p21).

Claimant- Refers to an individual of working age who receives a state benefit. Benefits include: Incapacity Benefit, Employment Support Allowance and Jobseeker's Allowance.

Employment Support Allowance- A state benefit which replaced Incapacity Benefit in October 2008 for all new claims. There are two groups: the Work Related Activity Group and the Support Group.

Health-related benefits- Refers to state benefits: Incapacity Benefit and Employment Support Allowance.

Incapacity Benefit- A state benefit that includes: Income Support, if given for incapacity and Severe Disablement Allowance (Beatty and Fothergill 2010).

Jobseeker's Allowance- A state benefit provided to working age adults who are required to actively seek work.

Prime- Refers to a primary Work Programme provider organisation that has been awarded a contract via the Department for Work and Pensions

Tier One Work Programme provider organisation- *'Subcontractors in Tier One of Work Programme supply chains are responsible for delivering the end-to-end process or a specific element of the service, such as job-broking'* (Lane et al. 2013, ix).

Tier Two Work Programme provider organisation- *Tier Two organisations work on a call-off basis, as and when a Tier One or prime contractor judges a participant could benefit from that organisation's help'* (Lane et al. 2013, ix).

Work Focused Interview- Refers to an interaction between a Personal Adviser and claimant which involves discussions around work (generally conducted face-to-face).

Work Programme provider organisation- Refers to an organisation which could be either a Prime or a subcontractor.

Chapter One: Introduction

'We do not believe that it is acceptable to write people off to a lifetime on benefits because they have a health condition or disability. We believe that many of these people could work, if they received the right support. But that support has not been forthcoming.' (Lord David Freud, Minister for Welfare Reform 2011a).

This thesis focuses on the way in which welfare claimants' health-related needs are understood and addressed within the new UK welfare-to-work era. The overarching aim of this thesis is to contribute to the body of knowledge relating to how support is provided for claimants with health-related needs within the UK welfare-to-work context. More specifically, the thesis focuses on the potential role of the Personal Adviser; a central frontline practice figure who has been extensively involved in implementing UK welfare-to-work policy. This chapter sets the scene by providing the background policy context relating to the study. The chapter identifies the research questions and objectives and provides an outline of the thesis structure.

Supporting claimants with health-related needs is an important policy issue in the UK, because there has been little change since the 1990's¹ in the large number of people of working age who are in receipt of health-related benefits² (Berthoud 2011). There have, however, been changes in the characteristics of Incapacity Benefit (IB) claimants since 2003: an increase in the number of women and younger people; a higher incidence of mental health and behavioural conditions; and a reduction in musculoskeletal conditions amongst

¹In the 1980's and early 1990's the number of IB claims increased (Beatty and Fothergill 2005). This increase coincided with the closure of certain industry resulting in challenging labour market conditions, and preferred financial incentives of IB over unemployment benefit, thus, diverting many of the unemployed to the sickness benefit - IB (Beatty and Fothergill 2005).

²Health-related benefits include Incapacity Benefit and Employment Support Allowance.

those claiming (Henderson, Glozier and Elliott 2005, Kemp and Davidson 2010). The high costs associated with supporting claimants, especially in terms of welfare benefits and health-related support services, has strengthened the need for policy to address this issue (Black 2008). Hence, the UK's welfare reform policies, both under the New Labour (1997-2010) and the Coalition government (2010 onwards) have increasingly focused on people making health-related benefit claims (Houston and Lindsay 2010, Lindsay and Houston 2011, Garthwaite 2011).

Given significant shifts in the policy landscape in recent years, I begin by outlining the welfare reforms set by the previous Labour government. Initially, in the late 1990's the Labour government's reforms introduced voluntary back to work programmes to encourage IB claimants to move into paid work via the New Deal for Disabled People (Department for Work and Pensions (DWP) 2002). However, these initiatives did not achieve the reduction in the number of IB claimants that was desired (DWP 2002, Economic and Social Research Council 2010). Thus, later in 2002, the Pathways to Work (PtW) policy, and the establishment of Jobcentre Plus (JCP) introduced a mandatory requirement for new IB3 claimants to attend Work Focused Interviews (WFI), shifting the focus of policy initiatives towards this group (Warren, Garthwaite and Bamba 2011).

The PtW policy was based on the premise that IB claimants had been unsupported, and therefore become 'passive' and 'inactive' (DWP 2002). Hence, "activation policies" were seen as necessary solutions (Houston and Lindsay 2010). Three key principles that underpinned the Labour government's reforms were to: provide claimants with support to improve their employability (DWP 2002); offer financial incentives to work; and to implement work related conditionality (Grover 2009). The Labour government supported its approach by referencing evidence that found paid work to be beneficial, not only for health (Waddell and Burton 2006), but also as a way to reduce poverty and social exclusion (DWP 2002, Black 2008).

The first seven pilot PtW programmes, led by JCP, were introduced in 2003. By April 2008, PtW were available across the UK with 60 percent being delivered

³Later in October 2008, this policy also included new Employment Support Allowance claims.

by private and voluntary sector provider organisations that were contracted by DWP (Hudson et al. 2010). Two key elements that were prescribed in the PtW policy were: the interventions of JCP Personal Advisers and a new voluntary health-related support element (termed Condition Management Programme (CMP) that would be provided by NHS healthcare professionals (DWP 2002). Thus, the integration of health and work support (Lindsay, Mcquaid and Dutton 2007) within the context of welfare-to-work was initiated. Other solutions proposed by the Labour government during the PtW period included the introduction of a new stricter medical assessment the Work Capability Assessment (WCA), which was initiated in October 2008 (to determine entitlement, to Employment Support Allowance (ESA) and replaced Incapacity Benefit) (Lindsay and Houston 2010) and plans for a reassessment of existing IB claimants. By February 2009, 68 percent of people who had undertaken a WCA were found 'fit for work' and therefore not eligible for ESA, 23 percent were assessed to be eligible for ESA and placed in the work related activity group (WRAG) (which has compulsory requirements to prepare for work), as opposed to nine percent assessed for the ESA support group (with no associated compulsory requirements) (Tarr 2010). Therefore, it can be argued that, Labour's reforms not only changed the way in which sickness benefit entitlement was structured, and employment support was delivered, but also sought to alter the way in which society perceived the relationship between sickness and work (Nice 2008).

The Coalition government were elected in March 2010. In May 2010 they proposed to '*...end all existing welfare to work programmes and create a single welfare to work programme to help all unemployed people get back into work*' (Cabinet Office 2010, p23). This new programme, called the Work Programme, was launched in June 2011. Unlike the PtW programme, which focused on Personal Adviser interventions and health-related support, the Work Programme does not have prescribed features. Instead, '*rather than asking providers to make one-size-fits-all services work for a wide range of participants with varying needs, government is providing freedom for providers to personalise support for the individual in a way that fits the local labour market. This is sometimes referred to as a 'black box' commissioning approach*' (DWP

2011, p9). Therefore, this policy assumes that Work Programme provider organisations will meet individuals' needs (DWP 2011a), with the principle of "personalisation" being a key underpinning feature (Toerein et al. 2013). The Coalition government's reforms have similarities to Labour's earlier policy direction (Patrick 2012), particularly in continuing to increase claimants' work related conditionality requirements and contract delivery through provider organisations (DWP 2010a, DWP 2010b). This raises key questions about how the Work Programme will be operationalized at the meso and micro level to address claimants' health-related needs.

The present PhD thesis began in September 2009 when I enrolled for PhD study. At that time my intention was to investigate the role of the Personal Adviser in supporting claimants with health conditions within the then PtW programme. Shortly after I began my PhD programme, the change in UK government brought significant changes in the welfare-to-work landscape as described above. However, given that Personal Advisers have been reported by the House of Commons Work and Pensions Committee (2011a) to play a key role in the Work Programme and by researchers for supporting any success of this new programme (Crawford and Parry 2010), an exploration of Personal Advisers was still considered important. Indeed, the Coalition's move away from prescribing employment support elements raises questions about whether and how Work Programme provider organisations will include Personal Adviser roles. These issues make a focus on Personal Advisers even more pertinent as key issues are raised.

A growing body of research literature, much of it sponsored by the DWP, investigates the practices and experiences of Personal Advisers and their clients. While some of this earlier work includes insights into how Personal Advisers and claimants address health related issues (for example, Knight et al. 2005, Hudson et al. 2009), to-date there has been little focused investigation and no attempt to develop a common understanding of the key issues facing policy makers and practitioners in this important area, especially within the context of the new Work Programme. This study begins to address this gap. The importance of this study's focus is also suggested by the differential treatment and exclusion from employment-related support that some claimants

with health conditions have experienced in employment support that was delivered by provider organisations (Hudson et al. 2010) and the difficulties that some Personal Advisers have encountered in supporting this group that have been documented in earlier research (Dickens, Mowlam and Woodfield 2004).

Furthermore, empirical evidence has revealed that while some claimants with ill-health do express a desire to work, many of this group perceive that their health problems affect their ability to work (Beatty et al. 2010), and illness is a contributory factor in why some people are unable to maintain employment prior to claiming benefits (Kemp and Davidson 2007, 2008) and re-enter the benefits system (Black and Frost 2011). Therefore, claimants' health issues can present real barriers to employment, and health improvements can influence their progression into work (Kemp and Davidson 2010). Thus, claimants' pre-work and post-work health issues are important and relevant, and should be appropriately acknowledged and addressed within welfare policy. This importance was reflected in the PtW programme with the introduction of the CMP (Lindsay and Dutton 2010). However, following recent welfare reform concerns have been raised regarding the extent to which health issues have been adequately addressed (Beatty et al. 2013, Lindsay and Dutton 2013, Warren, Garthwaite and Bamba 2011). Indeed, health issues seem to have less prominence in the Coalition government's Work Programme policy, with no prescribed health-related support provision. While a central theme that underpins the Coalition government's welfare reforms and Work Programme policy is personalised support (DWP 2011a), queries are raised in relation to whether and how such support will include attention to claimants' health-related needs and health-related barriers to employment.

This study recognises, but does not explore in any detail, other issues of support that some claimants with health conditions are likely to need, such as the development of skills and training or any limitations in the availability of suitable employment within local labour markets (Kemp and Davidson 2010, Beatty and Fothergill 2010).

Research objectives and questions

This study sets out to explore the role of the Personal Adviser and health-related support provision in the newly emerging welfare-to-work landscape. The primary research question is: what role does the Personal Adviser have in supporting the health of claimants with long-term illness? The study design aims to take into consideration the macro, meso and micro-level factors that characterise the policy arena, provider organisations that provide employment support and frontline practice. This is to be achieved by addressing the following five objectives:

Macro-level objectives:

1. To identify how welfare reform policy, particularly the Work Programme, aims to reduce the numbers of people with long-term illness who are claiming out-of-work benefits and to help them make progress into paid work.
2. To examine in detail how and in what ways the Work Programme is framed, particularly in providing health-related support provision.

Meso organisational-level objective:

3. To explore how Work Programme provider organisations interpret and operationalize welfare reform policy objectives within their delivery models.

Micro individual-level objectives:

4. To examine the role of the welfare-to-work Personal Adviser and identify the ways in which their practice supports or hampers claimants with long-term illness to manage their health whilst progressing towards paid work.
5. To explore whether and how claimants with health conditions experience support for their health-related needs from their welfare-to-work Personal Adviser.

These five objectives will be addressed by the following nine research questions.

1. To what extent are claimants' health-related needs considered within the Work Programme policy?

2. How is health-related support incorporated within Work Programme provider organisations' offers?
3. What types of health-related support are made available for claimants within the Work Programme?
4. What factors might influence the Work Programme provider organisations' provision of health-related support?
5. How do providers' organisational culture, structure and processes support/hamper Personal Advisers' practice in relation to addressing claimants' health-related needs?
6. What strategies do claimants with long-term illness adopt in order to manage their health whilst they participate within welfare-to-work provision?
7. What types and variations of health-related support do claimants access from their Personal Adviser?
8. What strategies do Personal Advisers adopt within their practice involving claimants with health-related needs?
9. What competencies does a Personal Adviser need to support their ways of working with claimants who have health-related needs?

Thesis outline

This thesis has nine chapters including this introduction. The following chapter establishes and debates the overarching theoretical framework for the study which is drawn from Lipsky's (1980) theory of street-level bureaucracy. Consideration is given to how this theory can inform an investigation of the macro, meso and micro level factors involved in welfare reform policy implementation that concerns claimants who have health-related needs. This chapter also defines and debates the six key concepts (Personal Adviser, health, long-term illness, barriers to employment, equity and personalisation) that are used in this study, and a seventh concept (disability) that was not included.

Chapter Three provides the backdrop to the study. It draws on the previous Labour and current Coalition governments' policy documents and related

literature to describe policy developments and employment support provision in recent years which relate to welfare provision and support to people with long-term illness. It identifies how policy has framed the role of the Personal Adviser, constructed claimants' health conditions, and made provision for claimants' health-related needs within employment support. It also gives an account of the developments of the Personal Adviser role. An overview of the Work Programme policy is provided and the emerging Work Programme evidence is reviewed. The chapter describes the choice and rationale for the research questions, raising issues and learning of relevance to the emergent welfare-to-work provision. These questions are pursued in the later Findings Chapters.

Chapter Four describes the research methodology and methods. It outlines my positionality, the research aim, objectives and questions. It explains why a qualitative methodology, drawing on ethnographic principles, was justified. Details are provided of the methods used to generate, analyse, interpret and draw conclusions from the data. This chapter also gives details of the ethical considerations and a reflexive account of the research process.

Chapter Five is the first of three Findings Chapters. This chapter adopts a theory-driven review approach to investigate how the role of the Personal Adviser has supported claimants with long-term illness. This is achieved through a synthesis of prior research evidence. Inevitably, this earlier material predates the Work Programme. However, this review is of value because it asks questions that are likely to have relevance for the Work Programme policy and in directing the focus of the current inquiry of this policy described in Chapters Six and Seven.

Chapter Six provides an integrated review of the Work Programme policy and practice landscape. It describes and explores the national level policy statements related to the Work Programme policy in order to examine the underlying assumptions and to identify potential risks of implementation. It examines how the Work Programme policy objectives have been interpreted by Prime Work Programme provider organisations to identify whether and how health-related support was proposed in their bids. To supplement this documentary analysis, I draw on new empirical data from my ethnographic

participant observations and research interviews with Work Programme stakeholders to explore how provider organisations have responded in practice.

Chapter Seven involves the micro-level interactions between Personal Advisers and their claimants and presents the findings from the practice-level empirical data within the current employment support provision. It explores how Personal Advisers' different role dimensions are played out in their everyday practice, and questions the salience of the demands of dealing with claimants' health issues. It examines the ways in which claimants respond to Personal Advisers during their interactions, and their views and experiences of the support they receive. These findings provide new insights into how Personal Advisers assess and address claimants' health-related needs within the Work Programme.

Chapter Eight seeks to integrate the findings across the various study components to address the research questions originally posed. The theoretical framework is revisited in light of the findings. The chapter considers how the trustworthiness of the study can be judged and the likely transferability of the findings. It also evaluates the strengths, limitations, relevance and importance of the study. This synthesis provides a more comprehensive picture of the extent to which claimants' health-related needs have been framed within current policy, and how policy has been interpreted by provider organisations and operationalized in Personal Advisers' practice at the frontline.

Chapter Nine discusses the study's key findings and themes in relation to the overarching research objectives. It explores the potential implications for policy and organisational practice, and identifies recommendations for further research. This chapter concludes by outlining several dissemination activities that have been undertaken, and those that are proposed for the future.

Chapter Two: Theoretical framework

2.1 Introduction

The purpose of this chapter is twofold. Firstly it outlines and discusses the overarching theoretical framework of this study which is drawn from Lipsky's (1980) theory of street-level bureaucracy. Lipsky's theory is useful in guiding the focus of this study because of its consideration of macro, meso and micro-level factors involved in policy implementation. As Wright notes (2003, p10) policy analysis needs to pay attention to '*...different constructs (e.g. the state), organisations (e.g. the Employment Service) and individual human actors (e.g. key politicians, civil servants or prominent campaigners as well as front-line workers and the recipients of public services themselves)*'. Though critiqued on a number of counts, including: no exploration outside of America (Winter 2002); a lack of consideration of varied levels of professional accountability (Hupe and Hill 2007); and 'homogenisation' of managers as one group (Evans 2011), Lipsky's work has been widely recognised and utilised across a range of policy and practice settings (Winter 2002). Furthermore, Lipsky is often cited in relation to frontline practice within the UK welfare-to-work context (see for example Sheppard (2009), Gaithwaite, Bamba and Warren (2013)). Additionally, it has been used as a theoretical framework for empirical research and analysis involving employment service provision (for example, Wright, (2003), Bertram (2010) and Grant (2011)). I consider below how Lipsky's ideas can inform my investigation of welfare reform policy implementation that concerns claimants who have long-term illness. Secondly, the chapter defines and debates the six key concepts (Personal Adviser, health, long-term illness, barriers to employment, equity and personalisation) that are used in this study, and a seventh concept (disability) that was considered but ultimately not employed. The chapter concludes by highlighting key areas of concern in relation to current welfare reforms and Lipsky's (1980) theoretical insights and the conceptual framework.

2.2 Street-Level bureaucracy

Lipsky's (1980) theory of street-level bureaucracy was developed through his observations of frontline workers' behaviour across various statutory sectors, including welfare, police and schools, in America in the late 1960s' and 1970's. Lipsky (1980) maintained that although these frontline workers, whom he labelled as "street-level bureaucrats", had different roles, they shared important similarities in terms of their structural work settings. His observations revealed that these workers' practice was challenging and often involved working with large numbers of clients in a short timeframe with high levels of discretion and *'relative autonomy from organisation's authority'* (p13). These factors led to practice dilemmas, especially when an organisation's resource constraints conflicted with the workers' ability to respond to client needs (Lipsky 1980). Consequently, frontline workers were observed to develop common 'patterns of practice' to cope with such challenges. Lipsky (1980) concluded that *'the decisions of street-level bureaucrats, the routines they establish and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out'* (Lipsky 1980, xii). Lipsky's analysis therefore countered conceptualisations that portray public policy making as a purely top down process, and revealed the central role of frontline workers in shaping policy on the ground. Lipsky's notions of 'discretion and autonomy', 'patterns of practice' and 'advocacy' are relevant to the present study's focus on welfare-to-work Personal Advisers.

2.2.1 Discretion and autonomy

Discretion and autonomy were two related features of frontline workers' practice identified by Lipsky (1980). He considered discretion in terms of frontline workers' decision making practice and in how they provided organisational benefits and sanctions to their clients. His reference to autonomy related to the way in which workers were managed and the level of independence they experienced in their practice. Lipsky (1980) argued that discretionary practice was necessary because the nature of street-level bureaucrats' work involved interactions with citizens that could be unpredictable. Therefore, they needed to be responsive to each interaction and to individual needs which inevitably demanded an element of personal judgement. Although Lipsky's (1980)

observations covered a broad spectrum of frontline worker roles, which he argued were required to *'exercise discretionary judgement in their field'* (p15), he acknowledged that not all street-level bureaucrats had professional status.

Additionally, street-level bureaucrats commonly interacted with mandated clients and therefore needed flexibility in applying eligibility criteria for services (Lipsky 1980). In these circumstances, although street-level bureaucrats followed assessment processes, they were often still required to determine whether a client met the criteria or not. Thus, in certain circumstances eligibility rules and regulations might only *guide* a street-level bureaucrat rather than provide a definitive answer. Lipsky (1980) also noted that street-level bureaucrats had a degree of autonomy and power in judging whether a client had provided a credible account and should be legitimately sanctioned or receive certain benefits and support. Bertram (2010) has extended Lipsky's analysis by noting that this type of discretionary practice can be *'contradictory and lead to practice 'pressures'* because while frontline workers need to apply certain rules they still retain a level of discretion in their practice decisions about whether and how they apply these (p55). Similarly, Loyens and Maesschalck (2010) point out, while discretion has been defined in different ways, *'it is always about a tension between general and abstract rules, on one hand, and specific situations, on the other- in other words, a flexibility versus uniformity dilemma'* (p67).

When analysing street-level bureaucrats' discretionary practice relationships with non-voluntary clients, Lipsky (1980) found they held a dominant position of power, making the nature of the relationship unequal. This position of authority, discretionary power, and control of the support and benefits on offer, also ensured that a client's behaviour could be controlled. In these circumstances, clients generally saw themselves as needing to comply and give consent, accepting that the street-level bureaucrat had a legitimate role in making decisions about their situation. However at the same time, it was evident that it was generally counterproductive for clients to do otherwise, because there were limited alternatives available. By displaying desired behaviour, clients aimed to please a street-level bureaucrat, and in keeping a frontline worker on side clients aimed to positively influence their future interactions. A range of 'client

strategies' were observed to be adopted in these types of interactions (Lipsky 1980). These included *passivity and acquiescence, expressions of empathy with workers' problems, and humble acceptance of their own responsibility for their situation'* (Lipsky 1980, p59). These insights indicate the importance of investigating the strategies that claimants with long-term illness adopt in their interactions and how these might shape their encounters.

Lipsky (1980) also observed the extent to which street-level bureaucrats' practice was managed within bureaucracies. His observations revealed that street-level bureaucrats generally operated autonomously away from the watchful eye of a supervisor, leaving scrutiny of their written records as a key way to supervise their practice (Lipsky 1980). Lipsky (1980) further identified that street-level bureaucrats questioned the legitimacy of their managers' directives, often preferring to exercise their own independent discretion. These factors made measuring street-level bureaucrats' job performance and evaluation of their work goals problematic, though not impossible (Lipsky 1980). Lipsky (2010) returned to the issue of managing street-level bureaucrats in his expanded edition of "Street Level Bureaucracy", and included some commentary relating to the UK. He proposed that a more defined management role is likely to be evident now than in the 1980's, given the principles of new public management that were introduced in Britain in the 1990's which may lessen the discretionary role of frontline workers (Lipsky 2010). Lipsky's (1980) insights indicate that discretion and autonomy are key areas of frontline workers' practice that are important to explore in this study.

2.2.2 Patterns of practice

Lipsky (1980) noted that street-level bureaucrats tended to adopt similar 'patterns of practice' in different roles and contexts. Common patterns of behaviour were established to mediate between organisational structural demands such as time restrictions, lack of information, resources and high caseloads (which typically involved mandatory clients) and organisational rules and regulations. These patterns of practice behaviour were utilised by street-level bureaucrats as coping mechanisms to support their practice which included, the establishment of practice routines. Routines served key purposes

that included: controlling the context of client interactions, and making tasks simpler, so that work was more manageable.

Another coping behaviour was street-level bureaucrats' conceptual categorisations of their clients. Differentiating between clients allowed some individuals to be better supported than others. This behaviour supported a third coping mechanism-rationalisation of their service and, therefore, a reduction in workload, for example, through supplying or withholding information from clients. Lipsky also observed how coping behaviours were not necessarily sanctioned by management and could conflict with policy goals (Lipsky 1980). However, by developing routines and simplifications, and applying discretion, street-level bureaucrats' practice dilemmas could be managed better. Therefore, their practice was altered according to what they considered achievable within their organisational constraints, and not necessarily what was of benefit to the client (Lipsky 1980).

While street-level bureaucrats were expected to give equal treatment to all people in common circumstances, in reality Lipsky (1980) recognised that organisational structural factors encouraged '*favouritism*' and '*unequal treatment*' (p151). Therefore, workers were found to introduce bias. Lipsky (1980) described three conditions that shaped instances of '*worker bias*': i) client-induced '*sympathy or hostility*'; ii) a client being considered to be '*worthy or unworthy*' involving a worker's moral judgement and; iii) a client being seen to be able to be more responsive than another (p108). Consequently, if street-level bureaucrats had large caseloads, which they struggled to manage, they '*... often choose (or skim off the top) those who seem most likely to succeed in terms of bureaucratic sources*' (p 107). This scenario can be referred to as '*creaming*' (p107) which was evident even when organisations had equality policies in situ (Lipsky 1980). Thus, Lipsky's (1980) insights suggest that street-level bureaucrats gave some clients preferential treatment. These ideas direct my investigation to frontline practice and illustrate the importance of exploring any differences in the way in which claimants with long-term illness receive support.

2.2.3 Advocacy

Lipsky also (1980) observed how street-level bureaucrats were expected to be able to enact an advocate role. As Finlay and Scandall (2009) point out, the concept of advocacy has been contested, however, Lipsky (1980) defined an advocate's role in being able *to use their knowledge, skill, and position to secure for clients the best treatment or position consistent with the constraints of the service*' (p72). Perhaps unsurprisingly, Lipsky (1980) found that this role dimension was more embedded in certain professional training than others (for example, lawyers and doctors). Nonetheless, even those without a defined professional status were found to adopt an advocacy role because their service aimed to help citizens (Lipsky 1980). However, the enactment of an advocacy role could be undermined by: large caseloads; restrictions of organisational resources; or limited resources (Lipsky 1980). In these situations, some street-level bureaucrats attempted to secure services for a client through organisational *'loopholes'* or resources at their discretion (p73). Being responsible for allocating resources highlights another street-level bureaucrat role dimension that is *'gatekeeping'* (Lipsky 1980). Importantly, by providing or limiting access to resources a street-level bureaucrat could contribute to either harming or promoting an individual's well-being (Lipsky 1980). Exploring this dimension has particular pertinence to the focus of the present study.

2.2.4 Relevance of Lipsky to this study

Several studies have found Lipsky's (1980) framework to be useful in guiding investigation of frontline workers' practice in Jobcentre Plus (JCP) (Wright, 2003; Grant, 2011 and Fetcher, 2011) and other provider organisations that deliver employment related support (Bertram 2010). Lipsky's (1980) work is relevant and applicable to guiding this current study because his theoretical insights reveal how policy making occurs at a number of levels with frontline workers playing a key role. In particular, the frontline role is indicated to be central not only in shaping how policy is implemented, but experienced and responded to by clients. Therefore, Lipsky's ideas shape the overall approach and direct the focus of my study to explore how policy is made at the macro, meso and micro level.

When applying Lipsky's insights to the current UK policy context, a number of issues are raised that direct the study further. These issues relate to key themes in relation to addressing claimants' health-related needs and include: the street-level bureaucrats' role of discretion and autonomy, patterns of practice, advocacy and 'gatekeeping' role dimensions and clients' responses. At the macro level, these themes relate to personalisation as discussed below. In addition they are linked to the way in which policy expects a frontline worker to also play an 'enforcer role' i.e. in applying work related conditionality measures as discussed in the next chapter. At the meso level, these themes concern the discretion and autonomy that Work Programme provider organisations have been given in designing and delivering their provision. In addition to Lipsky's insights into the ways in which organisational structures and cultures both constrain and give space for workers' to develop their own patterns of practice.

This includes understanding how Prime Work Programme provider organisations have interpreted the Work Programme policy and personalisation agenda and how they have operationalized the design of frontline worker roles to deliver policy objectives. Lipsky (2010) also acknowledged that there has been a shift in governments' approaches to contracting out public services to create innovation and cost savings. Newman (2007) asserts that this change broadens the way in which employment support programmes are governed. Such changes are apparent in the UK's welfare, especially in relation to the new Work Programme policy which has moved the delivery of employment support away from JCP to a wide range of private, public and third sector provider organisations.

It is anticipated that within the new welfare-to-work landscape, with the adoption of the "black box policy approach", there is likely to be a range of frontline worker roles operating across provider organisations, which have yet to be defined. Thus, the management of these frontline workers and the level of discretion and autonomy they experience may vary across different provider organisations. Additionally, as highlighted above, the individual nature of street-level bureaucrats' interactions with different clients is likely to lead to non-standardized responses (Lipsky 1980). These factors raise questions about

how Work Programme provider organisations will support and measure their frontline workers' practice that involves claimants with long-term illness.

At the micro level, Lipsky's (1980) theory has provided key insights into how frontline workers and claimants might respond in their interactions. In particular he emphasised how frontline workers apply discretion and autonomy. Lipsky's insights are useful because they remind us of the potential different motivations of frontline workers and other aspects of their practice, for example, in having to mediate between certain organisational structures and policy objectives whilst supporting clients which can cause tensions. These insights are further explored in this study in relation to supporting claimants with long-term illness. Lipsky's (1980) theory is also useful in directing our attention to how the role dimensions (advocacy and 'gatekeeping') might be played out in practice and to other role dimensions that may be adopted by frontline workers within the context of current welfare reforms. Lipsky noted that not all street-level bureaucrats had professional status but at the same time observed the expectation that they would exercise professional judgement. To practice autonomously professionals usually have expertise and a specialist body of knowledge that has been gained through training and qualifications, and importantly their accountability is governed by ethical standards (Wright 2003). Yet in contrast to many of the roles observed by Lipsky (1980), frontline workers within the UK welfare-to-work sector are less likely to follow a code of conduct because this is not unanimously enforced across the profession (Institute of Employability Professionals 2011). Furthermore, the professionalisation of the UK welfare-to-work Personal Adviser role is in its infancy as shown in Chapter Three (Crawford and Parry 2010). Therefore there is no standardised education/training qualification that would ensure the possession of the specialist body of knowledge that is meant to be a core requirement of professions. Thus, there are likely to be differences in frontline workers' skills and abilities which raise potential questions about their competency and ability in exercising professional judgement when working with claimants with long-term illness and health-related barriers to employment within the Work Programme. Lipsky's (1980) work also provides key theoretical insights which interrelate to the key concepts discussed below.

2.3 Key concepts

This section describes and discusses six key concepts that are used throughout this study: Personal Adviser, health, long-term illness, equity (in relation to health), barriers (health-related) to work and personalisation. It also explores the relationships between these concepts and Lipsky's (1980) key insights. A seventh concept that has not been included as a key concept for this study - disability - is also discussed and the rationale for exclusion is provided. It is important to note that the study draws upon social constructionism (as shown in Chapter Four); a perspective that considers how people define reality and create knowledge through their social interactions and thus socially construct meanings (Conrad and Barker 2010). Within this perspective, the meanings that are socially constructed through our interactions and language can shift and change over time within different contexts and culture (Warwick-Booth, Cross and Lowcock 2012). Therefore, while it is acknowledged that these concepts can be difficult to define, for the purpose of this study, I am interested to explore the multiple understandings and interpretations of six of these concepts and to examine how these shape people's behaviours and ultimately their responses at the intersection of health and work related issues.

2.3.1 Personal Adviser

The term Personal Adviser has been used throughout this thesis to describe the frontline role of a worker within a welfare-to-work context who provides employment support for claimants. These roles operate in JCP and other organisations that deliver back to work support programmes which are contracted by the Department for Work and Pensions (DWP). These organisations may be public, private or not for profit. Therefore, there have been a variety of adviser roles with different job titles operating within different welfare-to-work programmes (McNeil 2009). Whilst recognising that there are likely to be differences between frontline worker roles, for example, in terms of how they are recruited and trained (McNeil 2009) and the organisational culture where they are employed, the term Personal Adviser is adopted as a short hand.

2.3.2 Health

In defining health, the starting point for this study was firstly to explore the breath of understanding of what health means within the context of welfare-to-work policy. Secondly, the study seeks to understand the meanings that are ascribed by the different actors involved. Therefore, the study does not aim to investigate claimants who had particular specific health conditions or how policy and practice addressed these. Instead, the study aims to explore how the issue of health was framed at a macro policy level. In addition the study seeks to explore how support for claimants' health-related needs (referred to below as health-related barriers to employment) are addressed at the meso, organisational level and the micro level individual interactions of frontline workers and claimants.

In understanding the concept of health, it is considered difficult or even 'impossible to define' (Smith 2002, p883). Any attempts to do so need to incorporate various perspectives which include individuals' experiences (Warwick-Booth, Cross and Lowcock 2012). Health has been defined in many different ways within the literature, being positioned within historical and cultural contexts (Blaxter 2010, Warwick-Booth, Cross and Lowcock 2012). Therefore, the concept of health is not only subject to refinement (Blaxter 2010) and debate, but may alter as constructed meanings are applied within specific contexts.

Theoretically, health has been defined in relation to different models (Warwick-Booth, Cross and Lowcock 2012). These models include: medical, social and holistic which is considered parallel the biopsychosocial (Warwick-Booth, Cross and Lowcock 2012). Within the medical model of health (also known as biomedical), medical interventions are justified to respond to individuals' ill-health which has developed through disease (Yuill, Crinson and Duncan 2010). Therefore, ill-health is associated with the individual's body (Warwick-Booth, Cross and Lowcock 2012). In contrast, the social model of health incorporates many aspects of an individual's life including the wider societal influences such as *political, economic, social, psychological, cultural and environmental* (Earle 2007, p50). Focusing on the individual, the holistic model takes into consideration the 'whole' person which includes spiritual health (Warwick-Booth,

Cross and Lowcock 2012). The biopsychosocial model was initially developed by Engel in 1977. This model reflects biological, psychosocial and social dimensions of health and the way in which these interrelate (Engel 1977, Waddell and Aylward 2005). This model was drawn on in the health-related support element of the Pathways to Work (PtW) programme (the Condition Management Programme (CMP)) which is described in Chapter Three.

Despite the challenges in defining health, the World Health Organisation's (WHO)'s (1948) definition has been widely adopted (Larson 1999, Warwick-Booth, Cross and Lowcock 2012). In 1948, the WHO defined health as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" (WHO 1948 cited in 1946). However, the suitability of this definition has been widely debated (Warwick-Booth, Cross and Lowcock 2012). For example, WHO's (1948) emphasis on "*complete*" (Huber et al. 2011) and a lack of clarity in defining social well-being have been criticised (Larson 1999). The WHO's (1948) definition also fails to acknowledge that an individual may be able to manage a long-term condition (Huber et al. 2011). This is an important point given the changing nature of diseases, longer survival rates (Huber et al. 2011) and advancements in medical treatments that have shown to transform the illness experience for some individuals (Sanderson et al. 2011). Conversely, some people may describe themselves as healthy despite having a disease, (Warwick-Booth, Cross and Lowcock 2012) while others may not necessarily experience any associated symptoms of their disease (Blaxter 2010). These are important points for consideration in this thesis because they alert us to the fact that although a claimant may have a medical diagnosis, this does not necessarily mean they will self-identify as ill, have an "illness experience" or be unable to work due to illness.

Definitions of health have also emphasised positive or negative orientations. When health is approached from a positive perspective it is related to concepts such as 'wellbeing' or 'assets' (p9). Negative perspectives reflect on the absence of disease (Warwick-Booth, Cross and Lowcock 2012, p9). Other definitions of health emphasize different features (Warwick-Booth, Cross and Lowcock 2012), for example, as a function in being able to engage in everyday activities (Warwick-Booth, Cross and Lowcock 2012) which is closely

associated to an individual's fitness (Blaxter 2010). To some extent this definition resonates with the benefit's systems' medical assessment that determines an individual's entitlement to a health-related benefit. This medical assessment is focused on an individual's capability to work and the notion of fitness to work has been strongly emphasised by (Black 2008) as noted in Chapter Three. Health has also been defined as a commodity, being viewed as something that can be provided, for example, with medical interventions (Seedhouse 1986, Aggleton 1990, Warwick-Booth, Cross and Lowcock 2012). Within the welfare-to-work setting this would include a health-related support provision such as the CMP mentioned above. In summary, '*...the concept of health is not static or stable over time or within different contexts. It is influenced by a plethora of things and means different things to everyone*' (Warwick-Booth, Cross and Lowcock 2012, p11). Thus, rather than choosing a particular, fixed definition, an exploration of how the concept of claimants' health is constructed by Work Programme provider organisations, frontline workers and claimants themselves is integral to this study. Similarly, how these provider organisations and actors construct and come to understand the concept of long-term illness is a core element of investigation, as discussed below.

2.3.3 Long-term illness

For the purpose of this study, long-term illnesses relate to both physical and mental health conditions that are deemed longer-term. In defining long-term, (also referred to as chronic) illness, Radley (1994) asserts it is useful to draw a distinction between disease, illness and sickness. Disease typically refers to the medical profession's diagnosis of an illness, which is based on pathological changes in the body (Radley 1994). However, what is deemed to constitute a disease can vary across different cultures (Seedhouse 2001). Although pathological changes may not cause any initial symptoms, they eventually lead to an illness experience (Radley 1994). An illness experience has been defined as an individual's experience of being unwell in relation to their symptoms (Kleinman 1988, Waddell and Alyward 2005). Importantly, some individuals can experience illness in the absence of being given a definitive medical diagnosis (Dowrick et al. 2005) and some illnesses, such as fibromyalgia, have been contested by doctors (Jutel 2009). Consequently, while an individual may feel ill, in some situations they might only be judged to be genuinely ill or

affected by a disease following a medical diagnosis (Radley 1994). Within the welfare-to-work system, ill-health may be constructed in relation to work and benefit entitlement by various actors including policy makers, ministers, programme managers, Personal Advisers and claimants. Medical certification linked to a diagnosis or sickness label is required for entitlement to a health-related benefit. Therefore, the claimant's experience of illness alone may not necessarily provide: entitlement to a health-related benefit; exception from mandatory engagement in an employment support programme; or a referral to a health-related support provision.

Within the medical model, long-term (chronic) illness is defined by a permanent disease and on-going symptoms which typically require medical interventions and cannot be totally cured (Dowrick et al. 2005). In some circumstances, the disease may be controlled when an individual adheres to treatment (Ridder et al. 2008), and there are common ways in which self-management principles can be applied to help individuals manage different conditions (Dorwick et al. 2005). Common chronic diseases affect the cardiovascular system or the respiratory system, as well as arthritis, some forms of cancer, diabetes and epilepsy (Dowrick et al. 2005). Individuals who have one of these health conditions may have different experiences as disease progression can vary (Thorne et al. 2002). A long-term condition can also fluctuate, and an individual may experience episodes of remission or relapse, for example, as found in Multiple Sclerosis (Multiple Sclerosis Society 2014). Therefore, individuals with a long-term condition may have periods of time when they might feel either well or ill.

There has been a lack of consensus regarding whether mental health conditions should be termed long-term. For example, Parker (2005) has argued that there are different subtypes of depression and a range of treatment options that can lead to recovery in some cases. However, the Department of Health (2008) report both common and severe mental health conditions to be long-term conditions. Additionally, it is widely recognised that many people who have a long-term physical condition are at risk of developing a mental health problem (NHS INFORM 2014). Therefore, both long term physical and mental health conditions are included as long-term illnesses in the selection criteria in this study for: selection of secondary data sources used for the theory review

presented in Chapter Five and Work Programme bid analysis in Chapter Six, and participants who agreed to take part in the fieldwork observations and semi-structured interviews as presented in Chapter Seven.

2.3.4 Disability

Although long-term illness and disability are closely related (Ahmad 2000), and as Charmaz (2010) points out, empirical research involving long-term illness has yet to distinguish between illness and disability, disability was not a term employed in this study or used as criteria for selection of participants for the semi-structured interviews and fieldwork observations. This current study is interested in policy developments that relate to claimants who have long-term conditions, and how ill-health and its relationship to work is understood. It does not focus on whether claimants are deemed by others, or perceive themselves, to have a disability⁴. However, it is recognised that an individual with a long-term illness may experience impairments that could lead to disability, but that being 'disabled' does not necessarily lead to incapacity (Spicker 2003) or an inability to work (Waddell and Aylward 2005).

The concept of disability has been defined in many different ways, some of which have conflicting meanings and are subject to change over time (Gronvik 2009). Adding to this complexity is the varied way in which this concept has been operationalized within research studies (Gronvik 2009). To illustrate this Gronvik (2009) presents three disability definitions that have been used in research studies: i) *disability as functional limitation*, (which defines disability from a medical perspective in relation to altered functions of the body e.g. blindness,); ii) *administrative definition(s) of disability*; (which relates to people who have been granted welfare benefits on the grounds of disability) *and; H) a subjective definition of disability* (which concerns the individual's own identification to being a 'disabled person' (p2).

According to the WHO (2014), disabilities are seen as "*an umbrella term*" which incorporates three elements, '*impairments, activity limitations, and participation*

⁴ Legally in the UK, disability can only be determined by a judge who decides whether an individual meets the eligibility criteria that are outlined in the Equality Act 2010 (Equality and Human Rights Commission 2013). Within the context of welfare-to-work, a claimant can make a subjective assessment of whether they perceive themselves to be disabled or not.

restrictions'. Therefore within this definition, disability '*is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives*' and stretches beyond health issues (WHO 2014). Although the WHO's (2014) definition of disability reflects both medical and social factors, there have been two opposing models of disability: medical and social (Thomas 2004). The medical model considers an individual's health condition or impairment to be the fundamental cause of the disability (Oliver 1996, Waddell and Aylward 2005). Therefore, medical interventions are often perceived to be required (White 2009). In contrast, the social model views societal influences as oppressive and responsible for the prevention of equality in individuals' engagement, in standard roles such as employment (Oliver 1996, White 2009, Thomas 2004, Waddell and Aylward 2005). While there has been long standing criticisms about the social model's lack of recognition of impairment (Siebers 2008), Scambler and Scambler (2010) have suggested that there can be a slight merging between these two models. Nevertheless, whether the medical or social perspective is adopted, an individual with a disability or long-term illness is likely to experience factors that restrict their chances of gaining paid employment (Williams 2010). In summary, it was anticipated that some of the participants who took part in this study would consider themselves to be disabled, or be labelled by others as having a disability. However, I was interested in exploring how claimants' long-term conditions in relation to work were framed and understood in policy and supported in practice.

2.3.5 Barriers or obstacles to employment (related to health)

This study is interested in exploring the health-related barriers to employment that are experienced by claimants who have long-term illnesses. For the purpose of this study, the term health-related barrier has been adopted to encompass the wide range of health-related factors that can hinder a claimant's ability to secure paid employment. These barriers would include what the frontline worker and claimant understand to be a health-related need in relation to employment. Primarily this would include claimants' personal internal factors such as concerns about the side effects of their medication (Marwaha and Johnson 2005) or perception of their illness and ability to work (Beatty et al.

2010). But, given that internal and external barriers can interact, (Marwaha and Johnson 2005) external structural factors (as described below) that are considered important by either a frontline worker or claimant are also of relevance for investigation in this study.

While Waddell and Aylward (2005) suggest that 'obstacles' to employment are generally associated with clinical related literature and 'barriers' to employment with social policy literature, there is a lack of clarity (and arguably limited analytical gain) in distinguishing between these two terms. For example, Patel, Greasley and Watson's (2007) study about claimants with chronic pain used both terms. Therefore, barriers and obstacles appear to be synonymous terms and have been typically cited across a wide range of literature (e.g. empirical research, both quantitative and qualitative); policy documents and other grey literature that is associated with claimants moving into paid work. In empirical studies, barriers and obstacles typically relate to claimants': health issues; (for example, Beatty et al. 2010 and Kemp and Davidson 2010); employability factors such as a lack of skills; (Green and Shuttleworth 2010) and the wider structural factors such as employer discrimination (Kemp and Davidson 2010).

According to the social and medical models of health and disability, (presented above) the social model would consider that an employment related barrier would be defined in terms of external structural factors that hinder or prevent an individual from gaining work. Conversely, the medical model would assume that a person would require some form of treatment or intervention to address their personal barrier. Nonetheless, whatever term is adopted, it is apparent that, for some claimants, a health condition can present a number of difficulties when trying to move into work (Barnes et al. 2010, Casebourne et al. 2011).

Many claimants with health-related barriers to employment who have received health-related support interventions (i.e. the CMP within the PtW programme) have shown to experience positive health benefits as shown in Chapter Three. This suggests that the provision of health-related support has a potentially valuable role to play within the context of welfare-to-work provision and is therefore relevant to explore within the context of the Work Programme. Drawing on this prior work has emphasised the importance of addressing

claimants' health-related barriers to employment, and the potential value of claimants being able to access health-related provision within a welfare-to-work context as this can improve their health. Thus, within this study, the term health-related barrier has been adopted to encompass the wide range of holistic health-related factors that can hinder a claimant's ability to secure paid employment.

2.3.6 Equity (in relation to health)

There have been many contributions to defining the concept of equity (Morestin et al. 2010). Equity has been defined to mean '*fairness*' and relates to ethical values and human rights (Braveman and Gruskin 2003, p254). This current study draws on aspects of Morestin et al.'s (2010) definition of equity that has been adopted for the Canadian National Collaborating Centre for Healthy Public Policy described in Chapter Four. Morestin et al. (2010) identify '*two facets of equity (...): horizontal equity, which calls for similar treatment of individuals with similar needs; and vertical equity, which calls for different treatment of individuals with different needs, in proportion to the differences that exist between them (concretely: those with greater needs receive more, and the reverse)*' (p7). Within this study, equity is defined in relation to health and whether and how claimants with long-term illness receive equal treatment for equal needs i.e. health-related support for their health-related barriers to employment. In particular, it explores how health-related support is considered for different groups of claimants (with long-term illness) within welfare reform policies and the delivery of employment provision. Therefore, equity relates to the accessibility of health-related support provision and resource allocation within the context of welfare-to-work. This involves exploration of how Work Programme provider organisations have responded to addressing claimants' health-related needs.

Lipsky's (1980) insights have revealed several concerns in how discretion and autonomy may be applied by frontline workers and how they chose to allocate an organisation's resources to individual claimants. Empirical evidence has also found that some Personal Advisers can be inadequately trained, and therefore make their own interpretation of their role and determine the

legitimacy of claimants' needs (Fletcher 2011). Therefore, exploration of the way in which frontline workers enact their 'gatekeeping' role and allocate any health-related provision is important as well as ascertaining whether there are any variations in claimants' receipt of services across Work Programme provider organisations.

This study does not intend to measure any inequalities in claimants' health or to determine the effectiveness of health-related provision. Instead it aims to explore any concerns about disparities in health-related provision which link to Lipsky's (1980) insights into how frontline workers are subject to 'worker bias'. Bias is of concern given that street-level bureaucrats can favour some clients over others (Lipsky 1980). This is important to explore because preferential treatment has been identified in previous empirical research involving frontline workers in JCP and provider led organisations who deliver employment support. For example, JCP Personal Advisers have been shown to socially construct and categorise claimants which have resulted in adopting either positive or negative behaviours towards claimants, and, therefore, differential treatment or bias (Wright 2003, Rosenthal and Peccei 2006). Similar processes of categorisation of claimants have also been found in the provider organisation led PtW programmes that involved claimants with health conditions. For example, some claimants who were perceived as 'harder to help', because of the severity of their health condition were labelled '*reef*' and '*often given a bare minimum of service*' (Hudson et al. 2010, p52). These findings further emphasize the value of Lipsky's (1980) insights and raise important questions in relation to the Government's welfare reforms and the personalisation agenda (described in the next section) which expects a frontline worker to tailor their services to meet individuals' needs whilst at the same time employing an 'enforcer' role to ensure work related conditionality requirements are met.

Given that this study is interested in how frontline workers respond to supporting claimants who have long-term illness, understanding how health-related barriers are addressed by both provider organisations and frontline workers will be of importance. Lipsky's (1980) observations highlight that frontline workers' practice is open to bias which can be associated with wider

prejudices within society and whether they have sympathy for a client or deem them to be worthy. These insights are notable because the legitimacy of claimants' illness can be contested, particularly in the language used by ministers and in the media (Briant, Watson and Philo 2011, Garthwaite 2011). Therefore, pertinent questions are raised about how claimants with different long-term illness, might be perceived by frontline workers and whether these perceptions might affect their behaviour and support offered, thereby undermining equity.

2.3.7 Personalisation

For the purpose of this study, personalisation is defined according to Needham, (2010) who maintains that this is associated with the *tailoring of public services more closely to their users'* (p1). The concept of personalisation developed within the field of social care (Needham 2010) and has since permeated UK reforms under the Labour (McNeil 2009) and the Coalition governments (Needham 2011). As shown in the next chapter, the principle of personalisation has been used to justify many of the government reforms (Needham 2010), and is clearly evident in a number of welfare reform policy documents (Toerien et al. 2013) which include employment support provision (Needham 2010, Grover and Piggot 2013).

Although personalisation is closely related to individualised and tailored support, (Carr 2008), understanding this concept from a macro level perspective, within the context of policy documents can be problematic (Needham 2011). In particular this term may not be explicitly used, and its definitions are '*often vague*' (Needham 2011, p29) being '*elastic and contradictory*' (Toerien et al. 2013, p310). Consequently, this leaves the personalisation agenda open to interpretation and implementation by key policy stakeholders at both the meso and micro level (Needham 2011).

Within the context of welfare reform, (in particular the Work Programme policy) at the micro level, personalisation would involve the frontline worker role (e.g. Personal Adviser) who is responsible for delivering programmes of support and adopting a personalised approach (McNeil 2009). The Personal Adviser is likely to have considerable discretion and autonomy when implementing policy

goals (McNeil 2009, Torerien et al. 2013) which fits with the notion of personalisation. However, it is not clear how this concept will be interpreted and operationalized in practice in relation to claimants with long-term illness. Furthermore, it is not known what structural factors, particularly in terms of the availability of resources, (such as health-related support provision) and workloads that Work Programme provider organisations might impose on their frontline workers. The Work Programme's 'payment of results' model (as described in the next chapter) may also have some bearing on these issues. Therefore, exploration of whether and how claimants' health-related needs will be addressed equitably by provider organisations and/or their frontline staff is worthy of investigation. Chapter Three adds further insights into how personalisation has been indicated within the emerging Work Programme evidence.

2.4 Conclusion

This chapter has described and justified the choice of theoretical framework for this study. This framework relates to Lipsky's (1980) theory which is relevant in relation to the macro, meso and micro level factors that are involved in policy implementation and analysis, i.e. *'the entire policy environment in which street-level bureaucrats function'* (Lipsky 2010, p221). It has drawn upon Lipsky's (1980) theoretical insights which relate to frontline workers' practice in public service agencies revealing how they have operated within different contexts and structural constraints, often with large caseloads and limited resources. The discretionary and autonomous role of frontline workers is of importance to the focus of this study, and also how their patterns of practice may manifest in relation to supporting claimants with long-term illness within new welfare-to-work provision. Lipsky's (1980) theory has revealed key areas of concern in relation to frontline workers' practice which suggest that their ability to exercise discretion and autonomy and enact an advocate role may be problematic.

Seven key concepts have been debated and six of these (Personal Adviser, health, long-term illness, barriers to employment, equity and personalisation) have been used in this study. The complexity of defining these concepts has been discussed, revealing how they can be contested. Therefore, there are no uniform definitions to draw upon. In the next chapter I extend my discussion of

how the Personal Adviser's role has been framed in both the previous Labour and current Coalition government's policy documents and discourse. This is important given that these policies appear to be based on the premise that the Personal Adviser is not only motivated and able to make decisions, but is able to change claimants' behaviour (Wright 2012). I also consider how claimants' health-related problems and health-related support have been framed within policy documents.

Chapter Three: Literature informed review of UK welfare reform policy and employment support relating to claimants with long-term illness

3.1 Introduction

This chapter describes the context of current UK welfare-to-work practices within which Personal Advisers are expected to operate, and thereby enact policy objectives. It reviews past and current welfare reform policies and employment support relating to claimants with long-term illness. This includes policies set under both the New Labour government (1997-2010) covering the Pathways to Work (PtW) programme (2003-2011) and the Coalition government (2010 to present) who introduced the Work Programme in June 2011. The emerging Work Programme evidence that was available at the time of the study's conclusions in 2013 is also included. This work was an integral part of the study because it set out the context of welfare reform policy in which Personal Advisers practice, and helped to understand how previous employment support was intended to work. This exploration identified a number of issues and questions that are relevant for the Work Programme policy, revealing major gaps in knowledge about whether and how this new policy would support claimants with long-term illness. These findings subsequently shaped the focus of the current study. Reviewing aspects of the past PtW policy was also valuable, as later chapters of this thesis examine current provision of Personal Adviser and health-related support in both Work Programme provider organisations' offer and in practice on the ground. Therefore, this chapter's description of the PtW programme help the reader to understand and compare the study's findings in the broader context of past welfare-to-work provision. The chapter concludes by discussing the implications

of the review findings in relation to the choice and rationale for the current research questions.

The chapter has three sections. It begins by outlining the method undertaken for this review. The second section presents the review findings, first the past PtW programme and then the current Work Programme. The third section considers the future implications of the review findings.

3.2 Method

By drawing on a narrative approach, this policy review was intended to inform the current study. Exploring how the PtW policy proposed and delivered support to claimants with long-term illness was considered important to help gain an understanding of how this previous programme was expected to work. This information is useful because it not only provides the context of welfare-to-work practices, but helps to identify the policy expectations surrounding the Personal Adviser's role and a health-related support provision within a back to work programme. These findings shape the focus of the present study and analysis by highlighting pertinent questions and factors to explore in the current Work Programme policy.

The first part of the review focuses on exploring how the Labour government's welfare reform policies during the PtW period: constructed claimants' health conditions; framed the role of the Personal Adviser's practice with claimants who had health conditions; proposed claimants' health-related needs should be addressed; and delivered health-related support. Consideration is also given to the Labour government's key underlying ideologies and discourses relating to claimants who had health conditions. The second element of the review concerns policy documents set by the Coalition government in 2010. These are explored in relation to the Work Programme policy and Personal Adviser's role and support for claimants with long-term illness. Subsequent policy documents and literature sources (made available in 2011 till 2013) that related to the Work Programme delivery and empirical evidence are also included. These later sources help to describe the Work Programme model and identify current practice. This is intended to help the reader understand the context of the study

and also further emphasises the gaps in knowledge and justification for the chosen research focus.

The review adopts a mixed method approach and examines: policy documents and discourse; qualitative and quantitative empirical literature sources and reports that were considered to be key sources of evidence. It also incorporates earlier commentary from papers that have reviewed welfare reform policy and the wider empirical literature concerning long-term illness. Some of these sources helped to generate an understanding of the Labour and Coalition governments' underlying assumptions and ideologies surrounding their proposed solutions.

The Labour government's policy documents were identified and selected from the Department for Work and Pensions' (DWP) website. Documents were included if they made reference to the role of the Personal Adviser and claimants who had health conditions and were dated between 2002 and 2010. Ten Labour government policy documents were selected and included as presented in Table 3.1 in section 3.3.1. When searching for CMP related literature a systematic approach was adopted to strengthen the review's quality and limit any bias (Grant and Booth 2009). The search strategy involved: a search of DWP's website to identify PtW evaluations that were considered to be key evidence sources providing insights into Personal Advisers' and claimants' experiences of CMP, and the delivery model; and electronic databases across health and work. Thirty seven CMP literature sources were reviewed and details about these are provided in Appendix 1 and 2.

The Coalition government's policy documents dated 2010 were included in the review of the Work Programme policy as shown in Table 3.3 in section 3.3.2. In addition, a review of the Work Programme evidence so far was also undertaken to gain an understanding of the Work Programme delivery and experiences by the key stakeholders involved. The DWP has commissioned a series of official Work Programme evaluations (Lane et al. 2013). The first two evaluations, Newton et al. (2012) and Lane et al. (2013) were available following the completion of the present study and were included in the review. An internet search was also conducted to find any additional empirical evidence about the

Work Programme following its launch. This search included Prime Work Programme provider organisations' and subcontractors' websites and related organisations. Two reports were identified to be relevant from this element of the search.

3.3 Findings

3.3.1 Pathways to Work (2003-2011)

The PtW programme was introduced in 2003 following the 2002 Green Paper: *'Pathways to Work: Helping people into employment'* (DWP 2002). It was specifically targeted and designed for claimants in receipt of health-related benefits⁵ and aimed to pilot a variety of different interventions (DWP 2002). The key features of the PtW programme are shown in Box 3.1. Table 3.1 provides an initial descriptive analysis of the ten policy documents that were reviewed in terms of how the Personal Adviser's role and claimants' health-related problems were framed, and the health-related support solutions were proposed. The review focuses on two of the key solutions that were prescribed elements of the PtW policy: the role of the Personal Adviser and the Condition Management Programme (CMP). This first section describes how the Labour government's policy documents (during the PtW implementation period) and discourse have articulated the nature and consequences of claimants' ill-health. The wider empirical literature that relates to long-term illness is also considered in relation to how claimants' health-related problems have been framed within welfare reform policy statements.

⁵ Initially PtW was made designed for Incapacity Benefit claimants and later in 2008 included Employment Support Allowance claimants.

Table 3.1 Key welfare reform and policy documents from the New Labour government 2002-2010 concerning claimants with long-term illness

English Title	English Title	English Title	English Title
<p>2002: Welfare Reform Act</p> <p>2003: Welfare Reform Act</p> <p>2004: Welfare Reform Act</p> <p>2005: Welfare Reform Act</p> <p>2006: Welfare Reform Act</p> <p>2007: Welfare Reform Act</p> <p>2008: Welfare Reform Act</p> <p>2009: Welfare Reform Act</p> <p>2010: Welfare Reform Act</p>	<p>2002: Welfare Reform Act</p> <p>2003: Welfare Reform Act</p> <p>2004: Welfare Reform Act</p> <p>2005: Welfare Reform Act</p> <p>2006: Welfare Reform Act</p> <p>2007: Welfare Reform Act</p> <p>2008: Welfare Reform Act</p> <p>2009: Welfare Reform Act</p> <p>2010: Welfare Reform Act</p>	<p>2002: Welfare Reform Act</p> <p>2003: Welfare Reform Act</p> <p>2004: Welfare Reform Act</p> <p>2005: Welfare Reform Act</p> <p>2006: Welfare Reform Act</p> <p>2007: Welfare Reform Act</p> <p>2008: Welfare Reform Act</p> <p>2009: Welfare Reform Act</p> <p>2010: Welfare Reform Act</p>	<p>2002: Welfare Reform Act</p> <p>2003: Welfare Reform Act</p> <p>2004: Welfare Reform Act</p> <p>2005: Welfare Reform Act</p> <p>2006: Welfare Reform Act</p> <p>2007: Welfare Reform Act</p> <p>2008: Welfare Reform Act</p> <p>2009: Welfare Reform Act</p> <p>2010: Welfare Reform Act</p>

Policy/reform	Framing of claimants' health-related problems	Framing of the Personal Adviser role	Health-related support solutions
Welfare Reform Act	Proposals for implementing ESA and the introduction of the Work Capability Assessment (WCA).		
2007			
Freud Report, <i>Reducing Dependency, Increasing Opportunity</i> (Freud 2007).	<ul style="list-style-type: none"> • IB claimants were framed as 'hard to help' (p51). • New claims for IB were viewed as '<i>...a new generation with manageable mental health or musculoskeletal conditions</i>' (p28). 	<ul style="list-style-type: none"> • Acknowledged the positive contributions and 'crucial' role of Personal Advisers within Jobcentre Plus (JCP) and provider organisations (p78). • Claimants were considered to value a Personal Adviser who was '<i>well trained and sympathetic</i>' (p61). • Personal Advisers performed an 'enforcer' and 'enabler' role to ensure claimants' 'rights and responsibilities' were adhered to. 	<ul style="list-style-type: none"> • Support was needed to help claimants overcome their barriers.
2008			
Employment and Support Allowance	Introduction of the new WCA for all new claims relating to ill-health.		
Black Report: <i>Working For A Healthier Tomorrow</i> (Black 2008).	<ul style="list-style-type: none"> • The PtW Programme was considered inadequate in supporting claimants with mental health conditions. • Full recovery from ill-health was not required before a claimant was able to work. • Work could also support 	<ul style="list-style-type: none"> • Personal Advisers within JCP and provider-led organisations should be able to refer claimants to the Fit for Work service (2). 	<ul style="list-style-type: none"> • Individual Placement and Support programmes (3) might be beneficial for claimants who had severe mental health problems. • Vocational rehabilitation services needed to be incorporated within the

Policy/reform	Framing of claimants' health-related problems	Framing of the Personal Adviser role	Health-related support solutions
	recovery.		<ul style="list-style-type: none"> existing NHS services. NHS healthcare professionals should be better equipped to utilise a work-focused approach in their practice.
<p><i>Improving health And Work: Changing Lives The Government's Response to Dame Carol Black's Review Of The Health Of Britain's Working-age Population (DWP 2008a).</i></p>	<ul style="list-style-type: none"> A claimant's 'health status' should not prevent employment opportunities (p60). With the right support most claimants should be able to move into work. 	<ul style="list-style-type: none"> Proposed to trial placing Personal Advisers within GP surgeries and Improving Access to Psychological Therapy services (5). 	<ul style="list-style-type: none"> 'Basic healthcare and work management' should support most claimants into work (p9).
<p><i>Green Paper: No-One Written Off: Reforming Welfare To Reward Responsibility (DWP 2008b).</i></p>	<ul style="list-style-type: none"> The majority of claimants with health conditions were expected to recover, or to be able to adapt to their condition in order to return to work. Claimants' health problems were generally seen as able to be 'overcome' (p15). New Employment Support Allowance (ESA) claimants in the Work Related Activity Group (WRAG) would be required to 	<ul style="list-style-type: none"> Acknowledged the skills and expertise of JCP Personal Advisers. Personal Advisers were to be given more flexibility in their delivery of support to facilitate a more personalised approach. Personal Advisers would work with an ESA claimant to '... draw up a timetabled back-to-work action plan' (p15). 	<ul style="list-style-type: none"> Claimants would be able to discuss their plans for preparing for work with a medical professional during repeated Work Focused Health Related Assessments (WFHRA). Proposed to pilot the Fit for Work services. Proposed to enact the work-related activity elements of the 2007 Welfare Reform

Policy/reform	Framing of claimants' health-related problems	Framing of the Personal Adviser role	Health-related support solutions
	<p>take part in 'general' work related activities (p15).</p>	<ul style="list-style-type: none"> Personal Advisers would receive guidance about claimants' health-related return to work needs through the WFHRA. 	<p>Act for all new ESA claims in the WRAG from 2010.</p>
<p>Gregg Report: <i>Realising Potential: A Vision For Personalised Conditionality And Support</i> (Gregg 2008).</p>	<ul style="list-style-type: none"> Claimants should be able to access health-related support to help manage their conditions to engage in job seeking activities. Some claimants may need time to adjust to their health condition. Claimants: <i>'with the most severe mental health conditions; undertaking intravenous chemotherapy treatment; who are terminally ill'</i> are included in the no conditionality group (p64). These claimants should still be able to volunteer for back to work support. 	<ul style="list-style-type: none"> Personal Advisers should be given increased decision-making abilities. <i>'...virtually everyone claiming benefits and not in work should: (...) have an adviser with whom they will be able to plan and agree a route back to work...'</i> (p7). 	<ul style="list-style-type: none"> Health-related support should be made available based on individual need rather than benefit type. This included claimants who received JSA. The WFHRA element of the Work Capability Assessment (WCA) needed to be developed to identify the types of health-related support interventions that might be beneficial for claimants.
<p>White Paper: <i>Raising Expectations And Increasing Support: Reforming Welfare For The Future</i> (DWP 2008c).</p>	<ul style="list-style-type: none"> 90 percent of claimants who undertook a WCA were expected to be allocated ESA and placed in the WRAG. Claimants were expected to engage and agree work-related activities to support their health and transition into work. 	<ul style="list-style-type: none"> A PtW evaluation was cited which emphasised the importance of the Personal Adviser and claimant relationship. Personal Advisers were considered to have the ability to personalise support for 	<ul style="list-style-type: none"> Proposed to double the funding for Access to Work (6) to assist claimants with mental health and fluctuating conditions. Proposed to increase in-work support for people with health conditions.

Policy/reform	Framing of claimants' health-related problems	Framing of the Personal Adviser role	Health-related support solutions
	<ul style="list-style-type: none"> Emphasised mental health conditions and a need to have a better understanding of claimants' needs. 	<ul style="list-style-type: none"> claimants. Gregg's (2008) recommendations to implement personalised conditionality with the ethos of 'encouragement, co-operation and co-ownership' were acknowledged. Personal Advisers were also to be given additional flexibilities and powers to require some claimants to take part in certain activities if they were non-compliant (p91). 	
Pathways to Work Programme	National programme coverage.		
2009			
Welfare Reform Act Perkins, Farmer and Litchfield Report: <i>Realising Ambitions: Better Employment Support For People With A Mental Health Condition</i> (Perkins, Farmer and Litchfield 2009).	<p>Extensions of work-related activity for those in the Employment and Support Allowance – WRAG</p> <ul style="list-style-type: none"> Mental health conditions fluctuated, and did not necessarily follow a typical pattern of illness experience, duration of onset or lead to visible signs. People with mental health conditions could experience reduced levels of confidence and motivation. Some people who had mental 	<ul style="list-style-type: none"> The relationship between a Personal Adviser and the claimant was central to directing the right support. Continuity and flexibility of the Personal Adviser role was needed to ensure that support could be tailored. Personal Advisers were not considered to be specialists in mental health and needed to 	<ul style="list-style-type: none"> Better support was needed for people with mental health problems. Promoted the use of Individual Placement Support as a vocational rehabilitation approach (4), particularly for people with severe mental health conditions. Health-related support may

Policy/reform	Framing of claimants' health-related problems	Framing of the Personal Adviser role	Health-related support solutions
	<p>health conditions also experienced side effects from their medication.</p> <ul style="list-style-type: none"> • Claimants should not be expected to adhere to treatment as a condition of benefit entitlement. 	<p>work together with health services.</p> <ul style="list-style-type: none"> • Personal Advisers needed additional training (adopting a 'skills based approach') (p44) when working with claimants who have mental health conditions. 	<p>be needed at different times depending on claimants' needs.</p> <ul style="list-style-type: none"> • Healthcare professionals had a role to support claimants into work and needed to adopt a work-focused approach. • There should be consistency in the support provided across both work and health-related provision.
<p>Command Paper: <i>Building Bridges To Work: New Approaches To Tackling Long-term Worklessness</i> (DWP 2010b).</p>	<ul style="list-style-type: none"> • Claimants' health-related needs were individual and required an individualised approach. • Claimants who were assessed as 'fit for work' could also have health-related needs. • People with severe needs could access support through Work Choice. 	<ul style="list-style-type: none"> • Personal Advisers needed to be skilled to work with claimants who have health-related needs. • Proposed to give Personal Advisers additional time to support claimants. • Expected that the revised WFHRA would support Personal Advisers to know how to proceed with action-planning activities. This assessment was to be made available to claimants who had health conditions and received JSA. • Increased autonomy was 	<ul style="list-style-type: none"> • The PtW CMP was considered to be beneficial in improving claimants' self reported health and work readiness. • Health-related support was to be made available to all claimants who needed it irrespective of the benefit they received. • Proposed a new NHS-led health-related support provision to help claimants manage their condition. • The new health-related support was expected to be personalised, 'strongly work

Policy/reform	Framing of claimants' health-related problems	Framing of the Personal Adviser role	Health-related support solutions
		<p>expected to help a Personal Adviser find the right support for each claimant.</p>	<p><i>focused</i>' and flexible to accommodate individuals' needs which varied (p39).</p> <ul style="list-style-type: none"> • More support was to be made available through Access to Work, particularly for claimants with mental health-related needs.
<p>NOTE</p> <p>1. Condition Management Programme- A voluntary participation health-related support provision within Pathways to Work that was mainly delivered by healthcare professionals.</p> <p>2. Fit for Work services- <i>'A proposed new Fit for Work service, based on a case-managed, multidisciplinary approach, would provide treatment, advice and guidance for people in the early stages of sickness absence. With many people needing non-medical help, the case manager in the Fit for Work service would refer into a non-traditional, wide range of services, which could include advice and support for social concerns such as financial and housing issues as well as more traditional NHS services, such as physiotherapy and talking therapies'</i> (Black 2008, p12).</p> <p>3. Individual Placement Support- <i>'This integrates treatment and employment support and focuses on open, competitive employment commensurate with a person's needs and preferences. People are assisted to get a job as quickly as possible and then both employer and employee are provided with personalised support for as long as necessary'</i> (Perkins, Farmer and Litchfield 2009, p12).</p> <p>4. Vocational Rehabilitation- <i>'Vocational rehabilitation services address the specific health barriers to an individual's employment, as well as providing a source of information for the patient on the types of work which may be most suitable'</i> (Black 2008, p88).</p> <p>5. Improving Access to Psychological Therapies (IAPT)-IAPT services were initiated in 2006 and this programme provides health interventions to help people with different conditions for example, depression and anxiety (IAPT 2013).</p> <p>6. Access to Work- <i>'The Access to Work programme provides funding to remove the practical barriers that may prevent a disabled person working on equal terms, where it would be unreasonable to expect an employer to meet these costs. For example, Access to Work can help: meet the cost of sign language interpreters or support workers; meet any additional costs of travelling to and from work; buy specialist technological equipment that would help a disabled person do their job; or meet the costs of expert advice on adjusting the workplace or work practices to support disabled people in work'</i> (DWP 2008a, p40). Abbreviations: ESA- Employment Support Allowance, IAPT- Improving Access to Psychological Therapies, IB- Incapacity Benefit, JCP- Jobcentre Plus, JSA- Jobseeker's Allowance, NHS- National Health Service, WCA- Work Capability Assessment, WFHRA- Work Focused Health Related Assessment, WRAG- Work Related Activity Group.</p>			

Box 3.1 Elements of the Pathways to Work Programme

'Prior to the introduction of Employment Support Allowance, Pathways to Work consisted of a number of key elements:

- A Personal Capability Assessment (PCA) used to determine whether a customer is entitled to the benefit including a Capability Report focused on what a customer can do rather than what they are unable to do. Because of the nature of their illness, some people would be exempt from this assessment and any further mandatory involvement.
 - A mandatory Work Focused Interview (WFI) eight weeks after making a claim for IB (except in cases where this was deferred or waived due to the nature of the illness).
 - A screening tool at the initial WFI establishing who would have more WFIs and who would be exempt from further mandatory participation.
 - Access to a range of programmes to support the customer in preparing to work (the Choices package), including the New Deal for Disabled People and Condition Management Programme (CMP) which aims to help the customer to manage their health condition or disability so that they can get back to work.
 - A Return to Work Credit, where customers who enter employment can qualify for a weekly payment of £40 a week for up to 52 weeks, if their salary is £15,000 or less a year, and they meet certain other eligibility criteria.
 - In-Work Support (IWS): 'light touch' support provided by an IWS adviser to customers entering employment. Advisers may direct individuals towards further specialist support such as occupational health, job-coaching, general counselling or debt counselling.
- In summary, the implementation of ESA led to the replacement of the PCA with the Work Capability Assessment, and those customers assessed as being capable of looking for work [were] placed in the Work Related Activity Group. Those people with the most severe health conditions [were] placed in the Support Group and [were] excluded from any form of conditionality. They [could] participate in Pathways voluntarily. The introduction of ESA also led to the removal of the facility to waiver WFIs, and the removal of the WFI screening tool'.

Adapted from: Warrener, Graham and Arthur (2009, p8).

Constructions of claimants' health conditions

In 2002, there were 2.7 million IB claimants in the UK and almost two thirds of these claims related to one of three broad self-reported health conditions: mental health/behavioural (35%), circulatory or respiratory (11%) and muscular-skeletal disorder (22%) (DWP 2002). The Labour government's explanation for these high numbers was twofold. First, it considered that there was some failure of the individual to make a transition into work, and second that the state's system, had 'written *people off*' with little offer of support (DWP 2002, v). Whilst it was acknowledged in DWP's (2002) Green Paper that many IB claimants perceived their health condition could hinder their chances of employment, many were considered to be ill informed about their capability, rather than being too ill to work (DWP 2002). Hence, the majority of IB claimants' health-related conditions were framed as manageable and not considered to lead to impenetrable employment barriers (DWP 2002, Waddell and Alyward 2005). These types of conditions have since been increasingly described as "common health problems" (Waddell and Burton 2006) and "common chronic conditions" (Black 2010). Therefore, many people who experienced these conditions were expected to either recover or adapt as highlighted in Table 3.1 (DWP 2002, Freud 2007, DWP 2008a, DWP 2008b, Gregg 2008, DWP 2006, DWP 2010b). Claimants'(misguided) conceptualisation of their health in relation to work was also considered to be a wider problem within society, and a prime area that policy needed to address (DWP 2002). Thus, claimants, the benefits system (which would presumably include Personal Advisers' practice), healthcare provision and employers, were all considered to be part of the problem and the solution. Crucially, changing claimants' negative illness beliefs was thought to be possible if the right support was provided at the right time (DWP 2002).

A distinction between those who were deemed to be sick but capable of engaging in some form of paid work and those who had a legitimate sickness to be exempt from conditionality became prominent in DWP's (2002) paper. In contrast to the majority of IB claimants being deemed as capable of working, only a small percentage of people who received IB were viewed as having

severe disabilities making them less likely to be capable of entering paid work (DWP 2002). Examples of the severe types of health conditions that were given included: stroke and multiple sclerosis (DWP 2002, p13). This distinction was heightened further with the introduction of ESA, and the formulation of two tiers of groups (i.e. ESA Work Related Activity Group (WRAG) and ESA support group) raising concerns that some claimants are perceived to be more 'deserving' than others (Bambra and Smith 2010).

Reducing welfare dependency and promoting health through paid work

Minimising claimants' dependency on welfare benefits was of particular interest for the Labour government. Dependency posed a risk to individual's health and could lead to chronic disability and a more difficult journey into work (DWP 2002). As such, paid work was associated with not only providing positive health benefits, but to ensure people were not socially excluded or disadvantaged in the labour market (DWP 2002). Key health-related research evidence that supported the formulation of DWP's (2002) Green Paper included the Acheson Report (1998) (which outlined the consequences of unemployment and health), and the work of Waddell and Burton (2000) and Jones and West (1995). This body of research concerns two of the main self-reported health conditions: musculoskeletal, especially low back pain; and cardiac rehabilitation. Waddell and Burton's (2006) work continued to be influential as their evidence review titled: *Is work good for your health and well-being?* (commissioned by the DWP) was cited in later welfare reform policy documents (Freud 2007, Black 2008, and DWP 2008b).

In contrast to musculoskeletal and cardiovascular conditions, literature and research relating to mental health had less visibility in DWP's (2002) Green Paper. However, this evidence had a stronger prominence in later policy related documents, for example, two independent reports were commissioned by the DWP: *Working for a healthier tomorrow* which was published in 2008 by Professor Dame Carol Black, the UK National Director for Health and Work and *Realising ambitions: Better employment support for people with a mental health condition* by Perkins, Farmer and Litchfield (2009), (see Table 3.1). This change in emphasis seems to have corresponded with the increase in mental health and behavioural condition related benefit claims (Black 2008). In

addition, whilst the Labour government considered PtW to be a success (DWP 2008b) and that the CMP was helping claimants to address their barriers to employment (DWP 2006a), it was also recognised that more support for people with mental health conditions was required (Black 2008).

The reviewed Labour government policy documents paid less attention to (1) the potential adverse health effects of poor quality work, and changes within the labour market conditions, which can lead to more precarious types of employment and job insecurity (Ferrie et al. 2002, Benach and Muntaner 2007) (this was a stipulation in Waddell and Burton's (2006) review) and (2) the claim that those with health conditions can find themselves '*further back in the queue*' for jobs i.e. the significant obstacles to securing employment, than people without health issues (Beatty, Fothergill and Macmillan 2000, p621). There has also been limited acknowledgment within welfare reforms and policy discourse of claimants' 'lived experience' of illness (Grant 2011, Garthwaite 2011). Waddell and Aylward's (2005) monograph (*The Scientific and Conceptual Basis of Incapacity Benefits*), recognized that common health conditions can '*...cause considerable suffering, fully justify health care and may cause temporary restrictions*' (p34), but there seems to be little influence in the policy documents reviewed from the wealth of evidence which explores the experiences of people with long-term illness (Taylor and Bury 2007). For example, classic works by Charmaz (1983), Bury (1982) and Williams (1984) among many others show the significant disruption illness can bring to individuals' lives.

There is, however, some reference to the fluctuating nature of long-term conditions, for example, in DWP's (2006) Green Paper: '*A new deal for welfare: Empowering people to work*'. This Green Paper anticipated that Personal Advisers would need to support claimants with fluctuating health conditions by adopting a flexible approach (DWP 2006). In the independent review by Gregg (2008), a recommendation was also made for new benefit claimants who had health conditions to have a period of time to adjust (with a suggested period of three months). But what seems to be more commonly emphasised in the policy related documentation is that the majority of claimants' health-related needs can be managed to allow a transition into work (DWP 2002, DWP 2006, Freud 2007, Black 2008, Gregg 2008, DWP 2008a, DWP 2008b, Perkins, Farmer and Litchfield 2009, DWP 2010a). Thus, the PtW CMP (described in the following

section) was an appropriate choice of intervention, because this proposed to support the self-management of claimants' health conditions.

The framing of the Personal Adviser role

The Personal Adviser's role was considered to be central to the delivery of the PtW programme within the 2002 Green paper (DWP 2002) and the importance of this role continued to be emphasised within later reforms and policy documents (DWP 2006a, Freud 2007, Black 2008, DWP 2008a, DWP 2008b, Gregg 2008, DWP 2008c, Perkins, Farmer and Litchfield 2009, DWP 2010b). Initially this role referred to staff employed within JCP. A brief overview of the JCP Personal Adviser role is provided in Box 3.2. However, when PtW was expanded nationally in 2007 and 2008, involving delivery by provider-led organisations, this role also included Personal Advisers who worked outside of JCP. A key area of Personal Advisers' practice that was pivotal to the implementation of the PtW policy was the Work Focused Interview (WFI). WFIs were a mandatory requirement that new IB claimants⁶ had to participate in, or risk a reduction in their benefit entitlement. Three main aspects of WFIs and Personal Advisers' practice in relation to claimants' health that were documented in DWP's (2002) Green Paper were: i) promotion of positive messages to claimants about their ability to work; ii) identification of activities, through action planning, that could support claimants' progression into work; and iii) signposting claimants to health-related support (e.g. the new CMP, which was a new innovation integrating NHS-led health-related support provision within a welfare-to-work context) and other specialist provision.

⁶While many existing IB claimants could volunteer to take part in Pathways to Work programmes, mandatory participation for some people in this group was implemented in certain pilot JCP districts (Bewley, Dorsett and Ratto 2008). When the Work Capability Assessment was introduced in 2008, this requirement also included new claims for Employment Support Allowance.

Box 3.2 The Jobcentre Plus Personal Adviser role

This role was introduced in the New Deal Programmes in 1998 (Miller 2000, Dickens, Mowlam and Woodsfield 2004). In 2006 the National Audit Office broadly defined the Jobcentre Plus (JCP) Personal Adviser role by outlining key areas of their practice to: i) *'help people find work by diagnosing barriers to employment and helping people overcome them; and /) ensure that customers fulfil their responsibilities as a condition of claiming benefit, and help to protect the benefits system from fraud and error'*(National Audit Office (NAO) 2006, p6).

JCP have an in-house training procedure for Personal Advisers. In 2010 there was no formal qualification for Personal Advisers, instead Jobcentre Plus had a competency framework for new Personal Advisers (Crawford and Parry 2010). This framework had three levels of learning and development: entry, established and experienced. This was similar to the level of an NVQ 3 Level in advice and guidance. In 2010, JCP implemented its Advisory Services of the Future programme. This programme set out to improve Personal Adviser approaches and develop an accredited framework (Crawford and Parry 2010).

Equipping Personal Advisers

The 2002 Green Paper also recognised that to be effective, JCP PtW Personal Advisers would need to be better equipped and develop specialist skills (DWP 2002). It was envisaged that these skills could be developed through training, utilising the existing skills of JCP Disability Employment Advisers, New Deal for Disabled People Advisers, and other stakeholders who were considered to be more knowledgeable about working with IB claimants (DWP 2002, DWP 2003). Following DWP's (2002) Green Paper, the JCP Personal Adviser role evolved into a more specialised role termed Incapacity Benefits Personal Adviser (Dickens, Mowlam and Woodfield 2004). This new position was deemed necessary because an evaluation study (commissioned by the DWP) found that some Personal Advisers experienced difficulties in supporting people with health conditions and that there was a need to establish minimum standards of practice for JCP Personal Advisers (Dickens, Mowlam and Woodfield 2004). Similarly, although much later in 2009, proposals were initiated to professionalise Personal Advisers' practice within the welfare-to-work industry involving the private, public and not for profit sector (McNeil 2009). These developments are outlined in Table 3.2 and show that during the PtW period the Personal Advisers that worked for provider organisations were not required to adhere to any professional occupational standards.

Enabling and enforcing

The Personal Adviser's role was described as having an implicit 'enabler' and 'enforcer' dimension in many of the policy documents and related literature reviewed (as shown in Table 3.1 and Box 3.2), and explicitly in the empirical evidence, for example, in Knight et al. (2005). Therefore, there was an assumption and expectation that Personal Advisers would fulfil the dual purpose of not only preparing claimants with long-term illness for work, but ensuring they participated in certain activities to meet the conditions of benefit entitlement. These practice expectations were recommended to be increased over time which coincided with proposals to require claimants in the ESA WRAG group to engage in work related activities or face benefit sanctions (DWP 2008a). Making sure Personal Advisers had the ability to be flexible in their practice was considered essential to support such change (DWP 2008a). Similarly, additional flexibilities were recommended in an independent report: '*Realising potential: A vision for personalised conditionality and support*', (known as the Gregg review) that was commissioned and published by DWP in December 2008 (Gregg 2008). Gregg's (2008) review examined the way in which the benefits system could adopt a personalised conditionality regime and he proposed three different claimant groups as shown in Box 3.3. Only the third group of people (No Conditionality group) would be except from conditionality, because it was considered unreasonable for them to engage in activities to prepare for work (Gregg 2008).

Box 3.3 Three claimant groups proposed in Gregg's (2008) review

i. A 'Work-Ready' group: for people who are immediately job ready.

ii. A 'Progression to Work' group: aimed at those where a return to work is a possibility with time, encouragement and support, and where the conditionality:

- Reflect the claimant's co-ownership of the return to work process;*
- Be tailored to their capability and built around their circumstances;*
- Is based on activity that supports the clients' own path to work; and*
- Link up with effective support*

Hi. A 'No Conditionality' group: that involves no conditionality requirements whatsoever (Gregg 2008, p8).

Whilst Gregg (2008) acknowledged that people who were allocated JSA and placed in the Work Ready group could have health-related needs, people who were placed in the Progression to Work group (i.e. ESA WRAG) were likely to require longer to prepare for work. Three key elements of personalised conditionality that related to Personal Advisers' practice that Gregg (2008) recommended should be increased are shown in Box 3.4. In relation to the Progression to Work group, it was recommended that Personal Advisers should mutually agree work related activities with a claimant and formulate an action plan

In certain circumstances, it was also recommended that a Personal Adviser was given the power to direct claimants to take part in activities that were defined as work related, as shown in Box 3.4. The only limit to Personal Advisers "powers" that was made explicit in Gregg's (2008) review were, *'invasive medical treatments' or those that would clearly fall foul of human rights legislation or violate medical codes of practice'* (Gregg 2008, p54). Whilst Gregg (2008) asserted there should be safeguards within this aspect of Personal Advisers' practice (and acknowledged that there was no clear guidance available to help them to identify suitable work for those with 'serious health conditions'), there was an expectation that Personal Advisers would be capable of achieving this task.

Box 3.4 key elements of personalised conditionality that related to Personal Advisers' practice

- i) Flexibilities: An increase in this aspect of their role was advocated whilst recognising there was little evidence to demonstrate this would improve job outcomes.
 - ii) Discretion: To be able to make the decision to waive or defer claimants' appointments and decide whether the nature of the claimant's illness was a 'good' reason not to engage in work related activities.
 - iii) Power: To 'direct' claimants to participate in work related activities as defined within the 2007 Welfare Reform Act. This included circumstances: *'where a claimant has a proven, significant barrier to work which they have been encouraged to address but have failed to do so (for example attend a drug treatment programme); where a claimant has been sanctioned for failing to undertake any work-related activity or does not agree to undertake any work-related activity as part of the action planning process; and where a claimant's return to work activities are proving ineffective and they are unwilling to consider other options'* (Gregg 2008, P53).
-

Support to help Personal Advisers in this area of their work was recommended to be made available through the Work Focused Health Related Assessment (WFHRA⁷) element of the WCA (Gregg (2008). The WFHRA was to be made available to Personal Advisers to guide their discussions with a claimant about their perceived health-related needs in relation to a return to work (Hudson et al. 2010). However, at the same time it was acknowledged that the medical assessment for benefit entitlement could be improved (Black 2008, Gregg 2008). However, research evidence has revealed that Personal Advisers have struggled to make use of the Personal Capability Assessment, (the predecessor to the WCA) despite receiving a training pack and guidance notes (Legard et al. 2002). This finding raises questions about Personal Advisers' ability to interpret medical information and to be able to make use of such reports. DWP's (2009a) discussion paper titled: *1 Realising Potential: Developing personalised conditionality and support A discussion paper on the next steps in implementing the Gregg review,*' acknowledged that adequate guidance and training would need to be made available for JCP Personal Advisers. However, with the increased shift in contracting out employment support delivery to other provider organisations, questions are raised about how these measures were addressed across a diverse sector of private, public and not-for profit organisations. This issue was not made explicit in DWP's (2009a) discussion paper despite the proposals to pilot the new conditionality measures in a provider organisational led programme called Pathfinders.

Similarly, making sure that Personal Advisers were skilled for their practice with claimants with health conditions was a repeated theme within the reviewed documents (DWP 2002, DWP 2006, Perkins, Farmer and Litchfield 2009), but fewer details were made explicit about how this was to be achieved by Personal Advisers working outside of JCP. This suggests that the onus to prepare and train Personal Advisers was left to the discretion of provider organisations. This

⁷The WFHRA involved a discussion between a claimant and a healthcare professional to explore what types of support they perceived they would need in order to return to work. This element was suspended in July 2010 (Hudson et al. 2010, Tarr 2010).

was found to be the case in McNeil's (2009) research (outlined in Table 3.2). This research showed that the training Personal Advisers received from provider organisations tended to take place within their own organisation and by observing other Personal Advisers (McNeil 2009). This raises a number of questions about the preparedness of Personal Advisers within the Work Programme, particularly, in ascertaining what competencies they might need when working with claimants with long-term illness and what strategies they might employ in their practice with this group.

Addressing claimants' health-related needs

A second key back to work support solution proposed in the 2002 Green Paper was work-focused rehabilitation programmes, later termed as CMPs (DWP 2002). A new health-related support provision was needed to help claimants *'understand and assess the impact of their condition'*, because there was an identified gap in NHS rehabilitation services for claimants who had *'less serious conditions'* (DWP 2002, p29). This intervention was to be delivered by the NHS in partnership with JCP, and at a minimum address the three most common health conditions that claimants reported: mental health, musculoskeletal and cardio respiratory. Funding for the NHS-led CMPs was provided by DWP and this was not dependent on claimants completing CMP or moving into work (Lindsay and Dutton 2010). Following the expansion of the PtW programme, the responsibility for the design and delivery of CMPs moved away from the NHS. This move in 2007 encouraged further heterogeneity of CMPs under DWP's 'black box' commissioning approach which allowed contracted provider organisations to deliver PtW and fund a CMP within this. Although many of the non-NHS led CMP interventions could be selected at the discretion of the provider organisation, there was a requirement to consider the local IB claimant population needs and adhere to the NHS clinical governance standards (JCP 2006).

Condition Management Programme outcomes and delivery

The CMP review undertaken for the present study found strong evidence to show that although the PtW CMP was proposed to be a key intervention, many PtW claimants had not considered or been offered it in practice (Mitchell and Wood 2008, Hudson et al. 2009, Lindsay and Dutton 2010, Clayton et al. 2011).

There was no standardised CMP model across the PtW programme, but there were many common features. Similarities were found in terms of CMPs' content, interventional approaches and staffing backgrounds. Many of the studies reviewed found that the NHS-led CMPs adopted a biopsychosocial approach and Cognitive Behavioural Therapy (CBT) principles (Christie and Marshall 2008, Kellet et al. 2008, Ford and Plowright 2008, Lindsay and Dutton 2010). Similarly, some of the non-NHS led CMPs were found to adopt CBT approaches (Nice and Davidson 2010, Hayllar and Wood 2011) as well as other *'therapeutic approaches, e.g. psychodynamic counselling'* (Nice and Davidson 2010, p18). Across the studies, in both NHS and non-NHS led CMPs interventions were typically described to take place in a group, or face-to-face one-to-one sessions, or a combination of the two, with some participants having a choice of modules (e.g. Ford and Ploywright 2008, Nice and Davidson 2010). A range of healthcare related roles were used to provide these interventions which included allied healthcare professionals (Ford and Plowright 2008, Nice and Davidson 2010). Some of these CMPs also employed non-clinical staff (Ford and Plowright 2008, Reagon and Vincent 2010, Nice and Davidson 2010). A notable example of the difference between the CMPs concerned the limited involvement of the NHS within the non-NHS led CMPs, with only one paper reporting there had been collaboration in one PtW provider organisation (Lindsay and Dutton 2010).

Benefits for claimants' health

Gaining an understanding of the health benefits associated with the CMP is important because empirical evidence has shown that claimants' health-related issues can become barriers to employment (Kemp and Davidson 2010). Improvements in health can also help claimants, for example, in having a more equal chance of competing with other unemployed people in the labour market (Beatty et al. 2013). Despite the identified challenges in accessing or taking part in CMP, there was a general consensus in the qualitative studies reviewed, that many of the claimants who took part in CMPs (NHS-led and non-NHS led) had positive experiences (Cordon, Nice and Sainsbury 2005, Barnes and Hudson 2006a, Kellet et al. 2008, Hudson et al. 2009, Joyce et al. 2010, Reagon and Vincent 2010, Clayton et al. 2011). Improvements in claimants' self-reported health were also identified as outcomes of CMP in quantitative

studies (Ford and Plowright 2008, Hales et al. 2008, Hayllar, Sejersen and Wood 2010, Reagon and Vincent 2010, Kellet et al. 2011, Demou, Gibson and Macdonald 2012, Kellet et al. 2013,).

Conversely, both qualitative and quantitative studies found that a small number of CMP participants did not experience any health improvements (Ford and Plowright 2008, Kellet et al. 2013) and some were found to feel worse after participating (Ford and Plowright 2008, Nice and Davidson 2010, Kellet et al. 2011, Kellet et al. 2013). Some claimants also expressed a need for more focused support for their physical health conditions (Warrener, Graham and Arthur 2009, Macmillan Cancer Support 2010). Moreover, the short-term nature of the NHS-led CMP interventions did not suit all CMP participants. Therefore requirements for longer-term interventions, and follow-up support were raised by many claimants in both qualitative and quantitative studies (Corden, Nice and Sainsbury 2005, Bailey et al. 2007, Hales et al. 2008, Kellet et al. 2008, Ford and Plowright 2008, Warrener, Graham and Arthur 2009, Serjersen, Hayllar and Wood 2009, Reagon and Vincent 2010, Joyce et al. 2010, Macmillan Cancer Support 2010).

Benefits for Personal Advisers' practice

Two key CMP benefit themes that related to Personal Advisers' practice were identified in the review: i) being assisted by CMP practitioners to help claimants who had complex health issues (via increased knowledge about health conditions (Nice and Davidson 2010) and advice and guidance in how to respond to claimants' health issues (Dickens, Mowlam and Woodfield 2004, Barnes and Hudson 2006a, Knight et al. 2005). (ii) Benefiting Personal Advisers' interactions with claimants during their WFI's (Dickens, Mowlam and Woodfield 2004) (via positive changes in claimants' confidence, self esteem and optimism for the future (Knight et al. 2005), and increased willingness to talk (Dickens, Mowlam and Woodfield 2004). However, attaining these benefits was not straightforward, for although Personal Advisers were presumed to be able to perform a key 'gatekeeping' role in referring claimants to CMP (DWP 2002, JCP 2006), this required sufficient knowledge and an understanding about the potential benefits that CMP offered. Understanding CMP was a struggle for

some Personal Advisers (Dickens, Mowlam and Woodfield 2004), especially during the early stages of programme implementation (Knight et al. 2005). However, there was evidence from several of the qualitative studies to show that Personal Advisers' knowledge of CMP improved over time (Knight et al. 2005, Dixon, Mitchell and Dickens 2007, Lindsay and Dutton 2010). These findings raise a pertinent question about whether Personal Advisers' practice will integrate with any health-related services within the Work Programme which has shown to be of value.

Some of the identified gaps in the PtW CMPs delivery appear to have been considered by the Labour government as shown in their final reform paper: *'Building bridges to work: New approaches to tackling long-term worklessness'* (DWP 2010b). This paper set out proposals to develop a new expanded health-related support provision which would also be accessible on a voluntary basis to a wider group of claimants including those who received JSA (DWP 2010b). The new provision would be led by the NHS through a partnership agreement with JCP (DWP 2010b, p39). A tiered approach would be adopted, starting from providing claimants with simple advice and signposting, to more focused one-to-one or group sessions depending on individual needs (DWP 2010b). However, this new provision did not materialise following the change in government in 2010, and the proposals for the Work Programme described in the next section.

In summary, the review has shown that while many of the Labour government's policy documents described the majority of claimants' health conditions to be 'common' and 'manageable', they also recognised that a level of support might be required that combined both Personal Advisers and healthcare professional services. However, empirical evidence has shown that some Personal Advisers within PtW struggled to support some claimants with health-related needs, especially those with more challenging mental health conditions (Knight et al. 2005). This suggests that a more in-depth understanding of the Personal Adviser's practice with claimants with long-term illness is required.

The role of a Personal Adviser was framed as a key agent of policy implementation as both enabler and enforcer. This role was not only to support

claimants with health conditions to make progress towards working, but to start work. Moreover, the Personal Adviser was considered to be instrumental in helping claimants to access health-related support and given a key 'gatekeeping' role for the CMP within PtW. However, only a limited number of PtW claimants were offered or took part in CMP, raising questions about the effectiveness of the Personal Advisers' gatekeeping role. Therefore, research is needed to determine how any health-related support that is provided in the Work Programme will be made accessible to claimants with long-term illness. Importantly, while the findings showed there were many positive self reported health-related outcomes of the CMP, it was insufficient in meeting all of the participants' needs. Although CMPs were not responsible for job outcomes per say. they appear to have been judged on this basis in retrospect. For example, the NAO (2010) report that: ' *The voluntary aspects of support offered through Pathways (including the Condition Management Programme and the Return-to-Work Credit) appear to have no additional employment impact*' (NAO 2010, p9). These findings raise important questions about whether Prime Work Programme provider organisations will take on board the lessons learnt from the PtW CMP in their offers of health-related support.

3.3.2 Work Programme policy 2011-present

This section presents the findings from the review of the Coalition's government's policy documents and identifies areas of continuity with (as well as divergence from) the Labour government's policies. This is important because the review of the PtW programme evidence raised key issues and questions concerning the Personal Adviser role and health-related support that are likely to have relevance for the Work Programme policy. It also describes the Work Programme contract and delivery, before reviewing the emerging Work Programme evidence so far.

The Coalition government published a limited number of policy documents in 2010 that could provide explicit details about the Work Programme policy as shown in Table 3.3. However, what is made clear in that a single programme of support will be created (Cabinet Office 2010, DWP 2010b) that will help both JSA and ESA claimants move into sustainable employment, through the

support of provider organisations and their advisers (DWP 2010c). The review found that there was continuity of the Labour government's reform policies in several respects. Firstly, in relation to claimants' health, the Coalition government has continued to highlight the health-related benefits that are associated with being in work, for example, the work of Waddell and Burton (2006) has been frequently mentioned by the Minister for Welfare Reform, Lord Freud (2011b). Improvements to claimants' health are also emphasised as an outcome of the Coalition's reforms, which are considered to be gained by the adoption of a work-focused policy approach (DWP 2010a). The temporary nature of the majority of ESA claimants' health-related needs is also implicit in the White Paper: *'Universal Credit: Welfare that works'*. This paper set out the proposals to introduce a one year limit on contributions based ESA (DWP 2010a). Similarly, in line with Labour's policies, only people who are *'disabled or have a serious health condition which prevents them working and preparing for work'* are except from conditionality (DWP 2010a, p31).

Secondly, continuity can be seen in terms of a Personal Adviser's enforcer role dimension (DWP 2010c). This role dimension features strongly in the Coalition government's White Paper: *'Universal Credit: Welfare that works'* (DWP 2010a) which set out increased conditionality rules that would apply to ESA claimants in the WRAG. Thirdly, a Personal Adviser's enabler role is implicitly implied in the Government's personalisation agenda which requires support to be tailored to individuals (DWP 2011a). As discussed in Chapter Two, this raises a number of questions in terms of how personalisation will be responded to by Work Programme provider organisations.

There is less continuity, however, in the Coalition's policy in defining how claimants' health-related needs will be addressed. Importantly, there is no prescribed health-related support provision within the Work Programme policy, and as Deacon and Patrick (2011) note, no separate specialist programme, such as the PtW for claimants with health-related needs.⁸ Thus, it is unclear whether and how Work Programme claimants who have long-term illness and health-related needs will receive and experience any health-related support. In summary, while an adviser role was indicated to continue to play an important

⁸There is a specialist employment support provision for disabled people called Work Choice.

part in delivering the Coalition's reforms, particularly in terms of activation (DWP 2010a, DWP 2010c) and personalisation, this review identified major gaps in detail within current policy regarding the nature of frontline adviser roles and how they will support claimants with long term illness.

Contracts and delivery

The Work Programme is a single programme that aims to meet the different needs of nine claimant groups as shown in Table 3.4. As already discussed the Work Programme does not have prescribed features, instead Prime Work Programme provider organisations (subsequently referred to here as “Primes”) have been given the freedom and autonomy to deliver the choice of provision which they believe will meet peoples' needs. Operating on a 'payment by results' model, during the first three years of delivery, an initial attachment fee is received when a claimant starts a programme. Work Programme provider organisations are then financially rewarded through incremental payments after an individual sustains employment (DWP 2011a). These payments vary according to a claimant's benefit type (NAO 2012).

Primes were selected by DWP through a two tier process. First, in June 2010 organisations had to apply to be on the Framework for the Provision of Employment Related Support Services and then, if successful, could submit their contract bid in line with the Work Programme Specification and tender process in February 2011 (NAO 2012). The Coalition government expected Primes to select a supply chain that could support their programme, and many of these subcontractors were anticipated to be from the third sector (House of Commons Work and Pensions Committee 2011b). It was also expected that these subcontractors had the specialist expertise needed to support claimants who were viewed as 'harder to help'. For example, and of importance to the focus of this thesis, a subcontractor could offer a specialist health-related support provision such as condition management.

The Work Programme is split into 18 Contract Package Areas (CPA) across the UK and DWP awarded 40 contracts to 18 Primes. These organisations are from the private, public and voluntary sector. Each CPA has at least two, but some have three, Primes delivering programmes. In April 2011, the contracts were awarded for five years until March 2016, with an additional two years to complete delivery by 2018 (DWP 2011a9). Initially, Primes received an equal

⁹This policy paper was republished by DWP in December 2012.

number of referrals through random allocation by JCP. Importantly, claimants are not able to choose their Prime, but JCP provide a summarised copy of the organisation's Minimum Service Levels¹⁰ (MSL) at their point of referral. These levels are set by each Prime and are outlined in their bid. Claimants can refer to these MSL's if they want to make a complaint against their provider organisation. If Primes fail to meet their MSLs DWP may consider this to be a breach of contract (House of Commons Work and Pensions Committee 2011b).

Once referred, claimants can remain on the Work Programme for two years. If they gain, but subsequently leave, work during this period and re-enter the benefits system, they are typically expected to return to their previous provider organisation. If claimants have not secured work after two years, they are referred back to JCP.

¹⁰ MSLs are also referred to as minimum service standards, minimum service offers and minimum service delivery levels.

Table 3.4 Work Programme claimant groups

Claimant Group	Time of Referral	Basis for referral
1. Jobseeker's Allowance claimants aged 18 to 24	From nine months	Mandatory
2. Jobseeker's Allowance claimants aged 25 and over	From 12 months	Mandatory
3. Jobseeker's Allowance - Early Access claimants facing significant disadvantage	From three months	Mandatory or voluntary depending on circumstance
4. Jobseeker's Allowance claimants recently moved from Incapacity Benefit	From three months	Mandatory
5. Employment Support Allowance claimants who are unlikely to be fit for work in the short term	At any time	Voluntary
6. Employment Support Allowance claimants expected to be fit for work within three to six months	From the date of their work capability assessment	Mandatory
7. Employment Support Allowance claimants who have recently moved from Incapacity Benefits	At any time when claimants are expected to be fit for work within three or six months	Mandatory or voluntary depending on circumstance
8. Incapacity Benefit and Income Support (in England only)	At anytime	Voluntary
9. Prison leavers who claim Jobseeker's Allowance (referrals from March 2012)	Immediately when they make a claim within three months of their release from prison	Mandatory

NOTE 1: Group eight was added after the Department had issued the invitation to tender and before contractors had submitted bids. Group nine was added after Primes had been appointed, but the likelihood of changes was included in the invitation to tender.

Source: Department for Work and Pensions taken from National Audit Office 2012, p14.

Emerging Work Programme evidence so far

i) Newton et al.'s (2012) preliminary evaluation, titled: *'Work Programme evaluation: Findings from the first phase of qualitative research on programme delivery'* covered six of the 18 CPAs and was conducted in the first half of 2012. It included interviews with staff from 56 Work Programme provider organisations and 90 programme participants, and observations of frontline workers during their interactions with participants (conducted in four of the six CPAs). It identified that the overall delivery models of the included Work Programme provider organisations had comparable features. In terms of meeting the Coalition's government's personalisation agenda, some provider organisations were found to have developed procedural personalisation, (i.e. *'...high quality one-to-one relationships between participants and advisers, and the assessment and ongoing action planning activities'*), but substantive personalisation (*'...participants receiving distinct and, if appropriate, specialised support aimed at addressing their identified individual needs'* (p7) was variable. In addressing claimants' barriers to work (which included health), there was evidence of varied use of specialist provider organisations or spot purchase, with reports of frequent or no use. Moreover, interventions that were free (e.g. via the voluntary sector) or available from other funding sources were more typically used by Personal Advisers than those that resulted in additional costs. Overall, the evaluation was unable to determine if claimants' barriers to work were responded to effectively and accounts given by both Work Programme provider organisations and claimants about this were mixed. While this evaluation was unable to conclude whether creaming and parking practice was evident, there were examples of provider organisations concentrating their efforts on supporting 'job ready' claimants.

ii) Lane et al.'s (2013) evaluation titled: *'Work Programme evaluation: Procurement, supply chains and implementation of the commissioning model'*, also covered six of the 18 Work Programme CPAs. This evaluation was conducted towards the end of 2011 and in the summer of 2012. The data reported was drawn from qualitative interviews with senior people (i.e. directors and managers involved in the Work Programme and 25 stakeholders, from

DWP and JCP and an online survey completed by 200 Work Programme subcontractors. Although the findings from this evaluation highlighted that some of the original provider organisations (listed within the Primes' winning contracts) had left prior to the programme starting, there was no strong evidence to suggest that these organisations had only been listed as a means to gain a contract. Overall the financing model of the Work Programme was found to be challenging with fewer job outcomes than anticipated being achieved and subsequent payments received. Lane et al.'s (2013) also found that some provider organisations (Tier One) had reported to receive more referrals than anticipated, while other organisations (Tier Two) had received much less. Consequently, there were difficulties in relation to financing programmes as expected.

Similarly, the National Council for Voluntary Sector Organisations' (NCVO) (2012) survey (conducted a year after the launch of the programme) of the 18 Work Programme provider organisations' supply chain experiences revealed that some providers had received lower referrals from the Primes than expected. Additionally, there were concerns raised about some Primes providing support in-house rather than utilising their supply chain. These findings chime with Newton et al.'s (2012) study which documented advisers' reports that cost restrictions imposed by their organisations limited their access to support provision. Therefore in these cases, some advisers were more reliant on in-house support, or in helping claimants to access external support that was free (Newton et al. 2012). Limited use of specialist subcontractors was also found in Kerr's (2013) research which involved Work Programme subcontractor organisations and other providers of employment support in London. These findings suggest that claimants' receipt of health-related support (through specialist providers) is likely to be variable and patchy. Many of the supply chains who took part in the NCVO (2012) survey also reported to be subsidising the Work Programme contract from their own organisation's funds, thus, raising concerns about the sustainability of their programme (NCVO 2012).

3.4 Future implications and rationale for research

In light of the past and present policy context, and delivery of employment provision, this section considers the implications of the review findings for Personal Advisers' practice with claimants who have long-term illness. This review found that there has been recognition within policy and among wider commentators that the Personal Adviser was and is central to the implementation of welfare reform policy. In particular, it identified that the Personal Adviser is involved in activating claimants with health-related needs to prepare for work, and that this role demands particular competencies. The changing welfare-to-work landscape raises important questions about frontline workers' practice, particularly as the Work Programme is delivered outside of JCP. Thus, there is a need to examine any frontline roles and identify the ways in which their practice supports or hampers claimants with long-term illness to manage their health whilst progressing towards paid work. This is also important because the Personal Adviser profession is in the early stages of professionalisation, and a code of practice is not unanimously enforced. Therefore, there are likely to be variations in how frontline workers carry out their practice and in how different organisations prepare, support and manage their employees.

This review highlighted the potential benefits of having a health-related support provision within a welfare-to-work setting. It showed that the PtW CMP was beneficial in supporting some Personal Advisers' practice and facilitating improvements in many of the participants' self-reported health. The Coalition government's move away from having prescribed health-related support provision suggests that there is a need for research to explore whether and how claimants' health-related needs will be addressed within the Work Programme and whether provider organisations will include any health-related support. To date there has been no focused exploration of the health-related support elements of the Work Programme. Importantly, this issue is not indicated to be part of DWP's evaluation agenda, (Lane et al. 2013) which further justifies the importance of the current study. In particular, this gap further justifies the choice of the following research questions: How is health-related support incorporated within Work Programme provider organisations' offer? What types

of health-related support are made available for claimants within the Work Programme? What factors might influence the Work Programme provider organisations' provision of health-related support?

The emerging Work Programme evidence so far suggests that some claimants who have health-related needs may not be adequately supported. This evidence also implied that there may be considerable reliance on the relationship between a frontline worker and a claimant. Therefore, it is important to consider what competencies frontline workers need within the Work Programme to support their ways of working with claimants who have health-related needs. Chapter Two also raised several concerns in relation to Lipsky's (1980) theoretical insights in how discretion and autonomy may be applied by frontline workers and in how they chose to allocate an organisation's resources (which may be restricted) to individual clients. Therefore, an exploration of providers' organisational culture, structure and processes is needed to explore how these factors support or hamper Personal Advisers' practice in relation to addressing claimants' health-related needs.

3.5 Conclusion

This chapter has outlined the key policy developments under the previous Labour and current Coalition governments concerning claimants with long-term illness. Frontline workers - Personal Advisers - have been given a key role in implementing these policies. Both Labour and the Coalition governments' policy initiatives have shown continuity in their aim of increasing claimants' responsibilities through mandating participation in employment support programmes that has significant delivery through provider organisations. The Coalition government has contracted out the Work Programme to Primes that are expected to deliver this in line with the personalisation agenda. This leaves a gap in our understanding about how frontline roles will operate within the Work Programme. Similar questions have been raised in relation to understanding how claimants' health-related needs might be addressed. There has been less continuity in the Coalition's government policies in terms of ensuring claimants with health-related needs can access a health-related

support provision. Although health-related support through the CMP played a notable role in the delivery of the PtW policy and integrated health and work support within the context of the benefits system, it is clear that the current policy does not retain this core element, raising questions whether and how this will be provided. Further questions are raised in relation to the Coalition government's personalisation agenda and increased conditionality measures. Later chapters of this thesis return to these questions. The next chapter details the rationale and choice of methodology for this study.

Chapter Four: Methodology

4.1 Introduction

The purpose of this chapter is to describe how this research was conducted and to enable the reader to judge the study's quality, (Mason 2002) and importance.

The chapter begins by outlining my positionality and then the research aim, objectives and questions. This is followed by an explanation of my choice of a qualitative methodology. The methods section provides in-depth details about gathering the new empirical data, and the processes used to guide Chapter Five and Six. Information about how I applied the analytical framework for these two chapters are reserved for each corresponding chapter. I also provide an account of the ethical considerations and analysis of the new empirical data.

The chapter concludes by describing the approach taken to ensure quality and verification of the conclusions drawn. This section also provides a reflexive account of the research process.

4.2 Positionality

Personal beliefs, epistemic reasoning and related inferences can be influenced by our experiences, and are likely to have some bearing on our ontological and epistemological positions (Fumerton 2006). Therefore, in this section I outline why I was interested in the study's topic, how I feel about the issues raised (in relation to my experiences and healthcare professional role) and I reflect on how this may have shaped the research.

My interest in this study stems from my own journey into the world of welfare-to-work which was as a volunteer participant accessing a service. This involved meeting with a Disability Employment Adviser (DEA) at Jobcentre Plus (JCP). I initiated this meeting because my post, as an NHS Occupational Therapist, was to be terminated following a work-related injury. I sought guidance from the DEA about whether I would be perceived as 'disabled' by prospective

employers, and if my sickness absence record might prevent me from being employed. Thankfully, not long after this meeting, I walked through another welfare-to-work door as an employee, entering a new role as a manager for a Condition Management Programme (CMP) for a private organisation who delivered Pathways to Work (PtW) programme.

My experience in welfare-to-work provided opportunities to observe and discuss the challenges facing Personal Advisers, programme managers and claimants who had a health condition. During this period, I carried out workshops and one-to-one sessions with Personal Advisers to explore their difficulties in supporting claimants with health conditions. Personal Advisers expressed their concerns about exacerbating claimants' health, and talked about how they could struggle to help some people to progress. Some of these difficulties appeared to be linked to claimants who had certain medical conditions. Although many of these Personal Advisers wanted to help claimants, they appeared to lack sufficient knowledge and skills. There was some reluctance from the healthcare team that I managed to help Personal Advisers become more knowledgeable about health conditions. I became interested in this research because I wanted a better understanding of the challenges that some Personal Advisers experienced, and to identify ways to support their practice. I believe that some claimants benefit from work-related healthcare professional advice. However, I have also found that some healthcare professionals are unwilling, unable, or lack the confidence to engage in health and work-related conversations with their clients or patients.

Researcher versus healthcare professional role

I did not consider myself to have a dual role in relation to the research, but as I was registered with the Health and Care Professions Council I needed to abide by their professional code of conduct. I chose to briefly disclose my healthcare background to many of the participants involved in the study because I wanted to be honest. However, when conducting observations and interviews, I made a clear distinction between my healthcare and researcher role. As Schein (1987) advocates this can prevent any 'merging' of roles and avoid participants seeking health advice. Drawing on my healthcare knowledge felt appropriate in relation to benefiting participants, particularly Personal Advisers, who had given their

time and willingness to be involved in the study. Therefore, I did respond as a healthcare professional in certain circumstances. For example, when a Work Programme manager asked what might be necessary to consider when employing a healthcare professional in their organisation. I also offered to find out about any local NHS services that might be available to offer support.

I did question whether my healthcare professional role could be a hindrance as a researcher, for example, if Personal Advisers felt threatened by my knowledge when I observed their practice. Similarly, I considered whether claimants might reveal too much health information or expect that I could offer advice. Conversely, I wondered if claimants might share too little information if they perceived that I already understood their condition. These concerns did not appear to be an issue in practice. Similar reflections were made regarding my disclosure in relation to my work injury. I felt a brief disclosure to participants, particularly claimants, was important and could help establish trust, rapport and information sharing. Support for this approach can be found in the work of Oakley (1981) as she maintains that '*... in most cases, the goal of finding out about people through interviewing is best achieved when the relationship is non-hierarchical and when the interviewer is prepared to invest in his or her own personal identity in the relationship*' (Oakley 1981, p41).

My healthcare professional role and experiences were of value at different stages of the research, for example, when completing the ethics risk assessment and responding to claimants who became upset during their in-depth interview. Additionally these experiences supported my data gathering and analysis activities, for instance, when scrutinising the Work Programme provider organisations' bid documents for health-related information. From my experience of working in a PtW CMP, I also had some appreciation of how these bid documents need to be operationalized into 'real' services once contracts are awarded.

During the study my views about Personal Advisers' practice have altered. I have been more impressed by some Personal Advisers' approaches to supporting claimants with health-related needs than expected. I have also observed their commitment to try to help claimants have a better quality of life

by providing a wide range of support that is unrelated to employment. I feel that Personal Advisers should receive better recognition for this aspect of their work which can be overshadowed by the negative associations with welfare reform and some employment provider organisations' reputations. However, I remain concerned about the lack of role boundaries, in relation to addressing claimants' health-related needs in Personal Advisers' practice and this concern has increased my belief that there is a need for research in this area. Therefore, maintaining a reflexive approach throughout the research process was important. I engaged in a number of strategies to support reflexivity, such as keeping a research diary which are further outlined in my section below which describes my analysis and drawing conclusions.

4.3 Methodology: a multi-layered ethnographic approach

This section outlines the research objectives and questions and explains why a qualitative methodology, underpinned by ethnographic principles, is justified.

4.3.1 Research objectives and questions

This thesis is concerned with the way in which welfare claimants' health-related needs are understood and addressed within the new welfare-to-work era. The key focus is the Work Programme policy. The primary research question for this study is: What role does the welfare-to-work Personal Adviser have in supporting the health of claimants with long-term illness? Table 4.1 outlines the related research objectives, questions and corresponding chapters which contribute to answering these. These objectives and questions were refined as the study progressed. To help the reader navigate this thesis the research questions, which relate to, either the macro, meso or level factors have been colour coded. Table 4.1 also outlines the selected methods, data sources and justification which are discussed in section 4.4.

Table 4.1 Research objectives and questions

Macro policy environment objectives: **1.** To identify how welfare reform policy, particularly the Work Programme aims to reduce the numbers of people with long-term illness who are claiming out of work benefits and to help them make progress into paid work.
2. To examine in detail how and in what ways the Work Programme is framed in particular in providing health-related support provision.

Research questions:	Methods:	Justification:	Chapter:
1. To what extent are claimants' health-related needs considered within the Work Programme policy?	Policy and documentary analysis, participant observation of the welfare-to-work arena, observation of the practice arena and semi-structured interviews.	Analysis of welfare reform and Work Programme bid documents will provide information about whether and how claimants' health needs are considered. Engagement with stakeholders will provide information about how claimants' health-related needs are to be supported. Interviews with healthcare professionals will provide data on how health-related support provision is delivered.	Six.
2. How is health-related support incorporated within Work Programme provider organisations' offer?			

Meso organisational level objectives: **3.** To explore how Work Programme provider organisations interpret and operationalize welfare reform policy objectives within their delivery models.

Research questions:	Methods:	Justification:	Chapter:
3. What types of health-related support are made available for claimants within the Work Programme?	Documentary analysis, observation of the practice arena and semi-structured interviews.	Work Programme bid documents will provide information about delivery. Observations and interviews with stakeholders will reveal whether and how claimants' health-related needs are being addressed. Interviews with claimants may provide accounts of their health-related needs and experiences of any support provided. Interviews with	Six and Seven.
4. What factors might influence the Work Programme provider organisations' provision of health-related support?			
5. How do providers' organisational culture, structure and processes support/hamper Personal Advisers' practice in relation to addressing claimants' health-related needs?			

healthcare professionals will provide data on the types of health-related support that is available. Interviews with programme managers may provide data on the factors that influence delivery models.

Objective: 4. To examine the role of welfare-to-work Personal Advisers and identify the ways in which their practice supports or hampers claimants with long-term illness to manage their health whilst progressing towards paid work.

5. To explore whether and how claimants with health conditions experience support for their health-related needs from their welfare-to-work Personal Adviser.

Research questions:	Methods:	Justification:	Chapter:
6. What strategies do claimants with long-term illness adopt in order to manage their health whilst they participate within welfare-to-work provision?	Semi-structured interviews and observation of the practice arena.	Interviews with claimants may reveal information about their programme experiences. Practice observations will reveal ways in which Personal Advisers attend to claimants' health-related needs.	Seven.
7. What types and variations of health-related support do claimants access from their Personal Adviser?		Secondary data that are comparable will reveal information about Personal Advisers' practice with claimants who have health-related needs. Interviews with Personal Advisers will provide details about their practice decisions and may also reveal issues that relate to structural supports and constraints. Fieldwork observations will reveal how claimants and Personal Advisers behave and respond in interactions.	
8. What strategies do Personal Advisers adopt within their practice involving claimants with health-related needs?	Theory driven review drawing on realist review principles.		Five and Seven.
9. What competencies does a Personal Adviser need to support their ways of working with claimants who have health-related needs?	Semi-structured interviews and observation of the practice arena.		

Adapted from Mason (2002).

4.3.2 Ontological and epistemological positions

There is a range of qualitative methodologies and methods within a researcher's tool box, but the rationale for any selected approach needs to fit with the proposed research questions and researcher's ontological and epistemological position (Mason 2002).

Ontology concerns the way in which we perceive the world exists, and there are contrasting philosophical positions about this (Spencer et al. 2003). My ontological position aligns with the naturalist paradigm and constructed reality (Lincoln and Guba 1985) as presented in Table 4.2. In contrast to the positivist paradigm, naturalism assumes that there are multiple realities which are constructed by people who experience and take part in the same activities (Fetterman 2010).

Table 4.2 Lincoln and Guba (1985) Contrasting Positivist and Naturalist Axioms

Axioms About	Positivist Paradigm	Naturalist Paradigm
The nature of reality	Reality is single, tangible, and fragmentable	Realities are multiply, constructed, and holistic
The relationship of knower to the known	Knower and known are independent	Knower and known are inseparable and interactive
The possibility of generalization	Time and context free generalisations are possible	Only time-and context-bound working hypotheses (idiographic statements) are possible
The possibility of casual linkages	There are real causes before or simultaneous with effects	All entities are in a state of mutual simultaneous shaping, so that it is impossible to distinguish causes from effects
The role of values	Inquiry is value-free	Inquiry is value-bound

Lincoln and Guba (1985, p37).

Social constructionism is of relevance because this perspective considers how people define reality and create knowledge through their social interactions (Conrad and Barker 2010). This fits with my central interest in how ill-health is constructed in relation to work and benefit entitlement by various actors. This

includes policy makers, ministers, programme managers, Personal Advisers and claimants. The wider societal discourse may also be of interest. Thus, social constructionism provides a useful ontological perspective that can help to support understanding about how Personal Advisers and claimants form impressions about each other in their interactions. Understanding how both participants, (Personal Advisers and claimants), perceive illness in relation to claimants working, and whether they change their constructions through their face-to-face interactions is worth exploration in this study. It is also necessary to be aware of any influences of power that exist within society which can impact on our social interactions (Thomas 1993) and construction of meanings.

Epistemological beliefs concern how we come to know the world. They are important in relation to a researcher's relationship with research participants and the extent to which any knowledge claims can be made (Spencer et al. 2003). My epistemological position is interpretive that subjective knowledge is derived from our interpretations of both past and present events, and is also open to the influence of others. Therefore, I consider that my construction of knowledge about others may not only be different to those that I observe, but subject to change following my interactions.

4.3.3 Ethnography: fit for purpose?

A qualitative methodology was selected because the overall aim of this study was to gain a better understanding about the human actions, perceptions and experiences of different actors that are involved in providing welfare-to-work provision. Ethnography is an inductive and interpretive qualitative research methodology that aims to understand the world view of people through studies in natural everyday environments (Hammersley 1990). *'The aim of the ethnographer is to listen deeply to and/or to observe...'* (Forsey 2010, p567) events as they unfold to understand the experiences of those being observed, placing the emic-insider's perception of reality centre stage (Fetterman 2010). By using observation, the researcher has opportunities to consider events from different perspectives to those that are taking part (Rock 2001). Recent studies involving Personal Advisers and claimants demonstrate that fieldwork observations (Wright 2003, Grant 2011) and semi-structured interviews

(Bertram 2010, Grant 2011) are suited to welfare-to-work practice environments.

A more detailed examination of a culture is said to be achievable by adopting a critical approach to ethnography (Thomas 1993). A critical approach seeks to look beyond the world of the participants and to explore what else might be influencing the context and situations (Thomas 1993). A focus on power relations is then made possible (Vanderberg and Hall 2011). The critical perspective views '*... society to be unfair, unequal, and both subtly and overtly oppressive for many people*' (Carspecken 1996, p7). Therefore, by drawing on the principles of critical ethnography, it is hoped that a broader understanding of how welfare reform policy, employment provider organisational factors and wider society influences might impact on Personal Advisers' practice and claimants' experiences. Therefore, both emic and etic perspectives can be included, which Fetterman (2010) asserts makes 'good ethnography' (p22).

Although this study is interested in understanding Personal Adviser and claimant interactions, which could be explored just at the micro-level, it seeks to take a broader view of wider structural organisational and policy influences. This is beneficial because Personal Advisers may not necessarily be aware of such influences. Moreover, these influences could be embedded within an organisation's culture and therefore, perceived as the 'norm'. Thus, this study adopts a multi-layered ethnographic methodological approach, and a critical perspective in order to consider interrelated influences: policy, organisational and personal, which might concern Personal Advisers' practice as shown in Table 4.1. This study takes into account the:

i) Macro-level factors: which include welfare reform policy, to explore any impact upon provider organisations' delivery, Personal Advisers' practice and claimants' experiences.

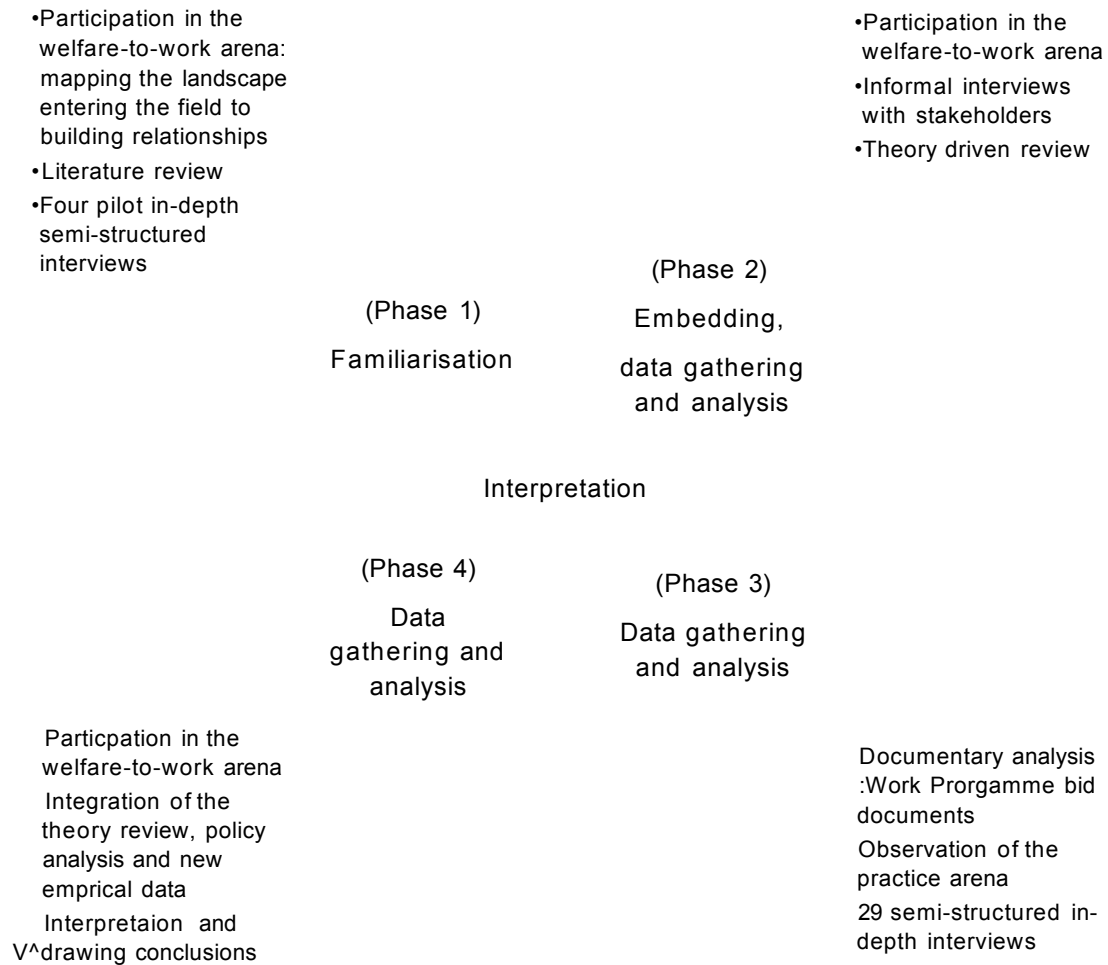
ii) Meso-level factors: which include the organisational structural and cultural context that may influence Personal Advisers' practice.

i) Jicro-level factor : which include the interactions between key actors in particular, Personal Advisers and claimants.

4.4 Methods

This section provides an overview of the research process and describes the methods used to generate the data and undertake analysis presented in Chapters Five, Six and Seven. The methods selected for different elements of the study were considered compatible, with consistent features and a "fit" with my ontological and epistemological position. A more detailed explanation and methods of application are described in relation to gathering new empirical data (presented in Chapter Six and Seven), while the processes applied to the selected methods (theory driven review and documentary analysis) for Chapters Five and Six, is provided at the start of each corresponding chapter. The purpose of describing the process is to familiarise the reader with the method. Figure 4.1 provides an overview of the research process and when each method was implemented.

Figure 4.1 Research phases and methods adopted



4.4.1 Theory driven review of how welfare-to-work Personal Advisers support claimants with long-term illness on their back to work journey

Chapter Five presents a theory driven review to look back at what has already been documented about the role of the Personal Adviser. This was guided by the principles of a realist review approach. A realist review aims to synthesize evidence to explain how complex interventions work. This is achieved by exploring any of the following issues: *'WHAT is it about the kind of interventions that works, for WHOM, and in what CIRCUMSTANCES, in what RESPECTS and WHY?'* (Pawson et al. 2005, p31). Complex interventions have a number of defining features, and are considered to be programme theories with active involvement of actors, who deliver interventions to achieve required outcomes (Pawson et al. 2005). A realist review aims to refine programme theories by identifying how these might change during a programme's implementation. This is achieved by exploring the interaction between the mechanisms and outcome by developing propositions which can be tested with the evidence (Pawson et al. 2005). The selection of evidence can include evidence that is relevant to the theory being tested but may be unrelated to the topic of investigation (Mays, Pope and Popay 2005). This approach recognises that complex interventions are *'embedded in social systems'* and are therefore, subject to the influence of context (Pawson et al. 2005, p7). The main stages of a realist review have been summarised in Box 4.1. However, each stage may be revisited during the process to explore new ideas, and questions that emerge (Pawson 2006).

Box 4.1 Summarised stages of a realist review

1. Defining the scope of the review and identifying how the interventions are supposed to work (programme theories).
2. Conducting a comprehensive search, appraisal of the literature and extraction of relevant data to test the theory.
3. Synthesis of the findings and refinement of the theory.
4. Drawing conclusions.

(Pawson et al. 2004).

4.4.2 Documentary analysis of the Work Programme

The Work Programme documentary analysis, presented in Chapter Six, was guided by the Canadian National Collaborating Centre for Healthy Public Policy's (NCCHHP) four stage method for synthesizing knowledge about public policies (Morestin et al. 2010). These four stages are presented in Figure 4.2. NCCHHP's approach uses an analytical framework to review the relationships between six selected factors: effectiveness, unintended effects, equity and implementation factors such as cost, feasibility and acceptability to explore potential policy outcomes and implementation issues (Morestin et al. 2010). The first step involves identifying the policy to be studied and reviewing related literature. This stage illuminates any issues and views about the policy which enables a logic model to be constructed (Morestin 2011). The construction of the logic model identifies, and breaks down and the intervention stages that are required to achieve the policy aim effectively. This process provides insights into the plausibility of the policy. The third stage involves a review of the literature which can include evidence from a range of qualitative and quantitative sources, including relevant grey literature. In order to extract data in a systematic way, NCCHPP recommend the use of their data extraction sheets which cover the dimensions within their framework. For the fourth stage, Moresetin et al. (2010) suggest the inclusion of deliberative processes and highlight the value that stakeholder perspectives can add to a policy synthesis.

In particular Morestin et al. (2010) maintain that, '*... dialogue can be established between experts, decision makers and other actors, for the purpose of critically examining an issue*' (p14). When adopting this approach the stages selected should meet the aims of the synthesis rather than follow their stages prescriptively (Morestin et al. 2010). Alternatively, as each stage has its own purpose and value they can be used independently (Morestin 2011).

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രണ്ട്

4.4.3 New empirical data generation

This section describes the three methods: participant observation of the welfare-to-work arena; observation of the practice arena; and semi-structured in-depth interviews that were employed to generate new empirical data. Following four pilot interviews conducted during implementation of the Labour government's policies, a total of 29 in-depth interviews were conducted, (during the current Coalition policy period and findings from these 29 are presented in Chapters Six and Seven. The four pilot interviews were useful not only in informing the study, for example, as Sampson (2004) points out, in identifying potential research questions and issues to explore, but in establishing useful contacts. Details of how these four pilot interviews (two with Personal Advisers and two with claimants) were conducted are included with the 29 in-depth interviews in this chapter and as shown, the same ethical principles were adhered to.

A wide range of methods, for example, participant observation, interviews, (both formal and informal) are available to the ethnographic researcher (Fetterman 2010). Participant observation of the welfare-to-work arena; observation of the practice arena; and semi-structured in-depth interviews, were selected because they could generate data that would contribute to answering the research questions as shown in Table 4.1. In addition, these methods could provide comparable data to support triangulation which is discussed in section 4.7.3.

Setting: practice observations and interviews

Entering the field involved participant observation of the wider welfare-to-work arena. This included attending a wide range of settings and events as shown in Table 4.3. These engagement activities were used to help build relationships with key stakeholders, to support further familiarisation of the topic area, and gain access to organisational settings as advocated by Barley (2011). As this research seeks to understand the role of the Personal Adviser and involves an 'encounter-within-context' (Spencer 1993, p377) (i.e. the interactions between a Personal Adviser and claimant), observation is best suited to take place in organisations that provide employment programmes where these types of encounters occur. Being immersed in welfare-to-work settings and observing Personal Advisers' practices, offers the added advantage of being able to explore events in natural settings, which might not normally be visible, an

approach suggested by Hodges, Kuper and Reeves (2008) or revealed in semi-structured interviews alone. Therefore, Work Programme provider organisations, where Personal Advisers work, were selected as appropriate settings.

- Think Tank updates e.g. Centre for Economic and Social Inclusion and Institute for Public Policy Research.
- Welfare-to-work related websites e.g. DWP, Employment Related Service Association.

NOTE: *Conferences attended include: The Welfare to Work Convention 2010. My presentations are listed in Chapter Nine*
(n=) relates to the number involved. () indicates an informal interview that was prearranged and lasted approximately 30-60 minutes.*

Sampling

Different sampling strategies were utilised for the three methods. The first method involved participation observation of the welfare-to-work arena. This involved both purposive and opportunistic sampling strategies. For example, I identified and made contact with key informants, who were considered to be experts in the topic area, through internet based searches and events. I also drew on my experience in the welfare-to-work sector to rekindle relationships and establish new ones.

The second method involved fieldwork observations of the practice arena. As this can be time consuming, the number of Work Programme provider organisations that could be involved in the study needed to be manageable. It was hoped that four provider organisations, including a Prime, would agree to take part. The two Primes that were awarded contracts to deliver the Work Programme in the geographical area where the study needed to take place were identified and contacted. However, because there were delays in gaining consent from Work Programme provider organisations, and the study had a restricted time frame, a pragmatic decision to include a Work Choice provider organisation was made. The data that could be gathered from the micro-level interactions between Personal Advisers and claimants with health conditions within this provision was considered to be comparable to the Work Programme and relevant to answering the micro-level research questions. Table 4.4 provides summarised details of the three provider organisations who took part in the study.

The third method was semi-structured interviews. In order to answer the micro-level research questions and gain in-depth experiences, a sample of Personal Advisers and claimants was required. However, where opportunities became available and/or new issues emerged, other welfare-to-work stakeholders were also selected to take part. This included programme managers and healthcare professionals. Table 4.5 and 4.6 provide details of the 29 participants who took part in the in-depth interviews for the main study.

All Personal Advisers who were willing to participate in the in-depth interviews and observations who worked in the Work Programme or Work Choice organisations were included. Attempts were made to have a sample that

included both male and female, covering a range of age groups, ethnicity, and level of experience and job roles. A purposive sample of claimants who had a diverse range of health conditions, age, ethnicity, class, educational background, time receiving benefit, benefit type and gender was initially sought, to make sure there was breadth in the sample. Claimants were excluded if they were unable to give informed consent, for example, because of mental capacity issues. However, recruiting claimants, especially those in receipt of ESA for the semi-structured interviews proved to be difficult, and an alternative sampling strategy was needed. Therefore, claimant recruitment strategies involved asking the first provider organisation to post a study leaflet and letter to claimants on the researcher's behalf. This organisation agreed, but this strategy proved to be unsuccessful. Thus, opportunistic sampling was employed because I had limited time in the field, and claimants appeared to respond positively once they had met me in person. Therefore, I either informed claimants about the study through face-to-face meetings, or study information sheets which were left in the providers' organisations.

Access

Access to provider organisations involved negotiations with a hierarchy of gatekeepers. The timing of the study coincided with significant changes in employment support provision. Therefore, gaining access to provider organisations was challenging, often demanding on going persistence and patience. During the initial stages of the study, discussions were held with primary gatekeepers- the Department for Work and Pensions (DWP) and JCP to explore JCP's involvement. JCP's Gatekeeper Team declined approval because of their ongoing business demands. Therefore, research could only be considered if it were commissioned by the DWP or JCP. However, receiving this decision coincided with the proposed welfare reform initiatives, after the election of the Coalition government in March 2010, and signalled a change within the welfare-to-work landscape. Thus, there was a need to ensure that the study would fit with these changes. However, at this time there were uncertainties about the proposed new Work Programme, and which organisations would be awarded contracts.

Having an introduction into the field can be beneficial (Fetterman 2010), therefore once the Work Programme contracts had been awarded I drew on my

network of contacts to assist with gaining access to organisations. Primes' contact names were provided by an informant. The two Primes in the study's locality were contacted by email and both of these organisations responded. The regional manager of one of these organisations agreed to send an introductory email about the study to four Work Programme subcontractor organisations within their supply chain. These four organisations delivered end to end provision (i.e. they continued to support a claimant for a period of time to prepare for work following an initial assessment). In addition, three of these provider organisations had a specialist role or provided a specialist health intervention. Three out of these four subcontractor organisations (two from the non for profit sector and one from the private sector) gave approval for the study. One of the non for profit organisations provided claimants with up to two years programme support and one for less than a year. The organisation from the private sector did not have a specialist role or intervention and provided employment support for less than a year.

Following agreements from these three organisations' overarching managers to go ahead with the study, there were ongoing negotiations with local office managers to gain access to Personal Advisers and healthcare professionals, and with Personal Advisers to gain access to claimants. Therefore, there were initial face-to-face meetings with managers and Personal Advisers within these three organisations. The organisation from the private sector, later withdrew any further involvement before the fieldwork was due to start. Numerous emails and a face-to-face meeting was held with the second Prime, but access was not negotiated.

Having familiarity with a culture is considered beneficial to facilitate access (Whyte 1984), and this seemed to help to some extent. For example, I outlined my relevant work and personal experiences, as described in section 4.2, in email communications which may have enabled me to be perceived as 'an insider' (Sanger 1996). Another strategy to inform organisations about the study was co-hosting a Learning Event: 'What part does "health" have to play in the success of the Work Programme?' in collaboration with the South Yorkshire PtW NHS-led CMP in March 2011. One of the aims of this event was to highlight the contribution that health-related support provision within the Work Programme could offer. Therefore, a wide range of potential Work Programme

provider organisations were invited, and many attended this event. I presented my findings concerning the role of the Personal Adviser (presented in Chapter Five) and informed attendees about the study. One organisation (that subsequently did not secure a Work Programme contract in the study locality, but delivered Work Choice) responded positively at this event and later became part of the study. Summarised details about the organisations that took part in this study are shown in Table 4.4. Opportunities to observe daily team meetings and to have access to internal organisational documents were made available in one organisation. Two of the three organisations moved location during the study period, and all three had staff changes including managers which added complexity to the study.

The study's sample is limited by the lack of inclusion of a Prime's delivery, and private provider organisation. Therefore, there are potential limitations in the transferability of the findings, particularly to Prime and private organisations. However, given that all Work Programme subcontractors are required to follow their Primes' minimum service levels, it was anticipated that there might be similarities across provider organisations in terms of their delivery models and need to deliver results. In addition, it is important to note that the initial introductory meeting with a Work Programme subcontractor organisation from the private sector (who withdrew from further involvement at a later stage) yielded data. This included a 70 minute introduction/group discussion with the organisations' team of 8 Personal Advisers (four male/four female) and their manager. Additional data about Primes and private Work Programme organisations were gathered from my wider participation of the welfare-to-work arena, for example, in informal conversations with Work Programme provider organisations as shown in Table 4.3, and in one of the Personal Adviser interviews there were opportunities to discuss this participant's previous practice for a Prime from the private sector.

Similarly, there are limitations in the number of in-depth interviews with claimants who received ESA. However, claimants in receipt of ESA were observed and talked to during the fieldwork, and many of the claimants who were interviewed had received ESA or IB previously. Importantly, at the time of the study there were fewer ESA referrals made to the Work Programme than expected (House of Commons Work and Pensions Committee 2013).

Therefore, there were fewer opportunities than anticipated to recruit claimants who received ESA. Similarly, many of the claimants with long-term illness who were observed to participate in the Work Choice programme were noted to receive JSA rather than ESA.

Table 4.4 Summary details of the participating organisations and volume and range of data generated

	Site One (non-profit sector end to end delivery with specialist role)	Site Two (non-profit sector end to end with specialist intervention)	Site Three (non-profit sector end to end with specialist role)
Description	Office type: formal with 1:1 rooms, semi-open plan area and group rooms.	Office type semi-informal, private 1:1 rooms and group room.	Office type: formal with open plan area, group rooms sometimes used for 1:1s.
Staff mix	Managers, Personal Advisers, administrator and volunteers.	Managers, Personal Advisers, healthcare professionals, administrator and volunteers.	Managers, Personal Advisers and administrator.
Staff turnover	Manager, Personal Advisers and administrator.	Manager and administrator.	Manager and Personal Advisers.
Events observed	1:1 face-to-face interviews and telephone interactions with claimants. Group work: job clubs, preparing for job applications and motivational workshops. Team/supervision meetings. Claimant waiting area. Peer discussions: claimants and Personal Advisers. Reception area. Interactions involving claimants' parents.	1:1 face-to-face interviews and telephone interactions with claimants. Group work: welcome inductions, Condition Management Programme session. Claimant waiting area. Peer discussions: claimants and Personal Advisers. Reception area. Interactions involving claimants' carers.	1:1 face-to-face interviews and telephone interactions with claimants. Group work: job clubs. Claimant waiting area. Peer discussions: claimants and Personal Advisers. Reception area. Interactions involving claimants' carers /partners.
Artefacts /data sources available for reviewing	Posters, notice boards, leaflets, claimants' feedback forms, action plans, claimants' appointment letters, group resources, intranet policies and procedure manuals, organisational statistical information, power point slides and videos for group work, flip charts and claimants' thank you cards.	Posters, leaflets and Power point slides for group work.	Notice boards, leaflets, and group work manuals.
Participants	ESA and JSA	ESA and JSA	ESA and JSA

observed

Duration of observations	Covered 11 days	Covered 12 days	Covered 9 days
Number of Words documented	Field notes and memos n=28488	Field notes and memos n=13296	Field notes and memos n=17215

NOTE: Observation sessions included a whole /half day, individual interview and in-house group activities. Two external venues were also included on several occasions- one informal community location and one volunteer centre.

Abbreviations; ESA- Employment Support Allowance, JSA-Jobseeker's Allowance.

Table 4.5 Summarised participant characteristics from the 29 semi-structured interviews

Semi-structured interviews	Number	Sex	Age	Benefit type and duration	Interview length range of time	interview method
Personal Advisers	11 WC 4 WP 7	4 male 7 female	Range 26 to 53 mean age 36.6*		30-60 minutes	10 face- to- face 1 telephone
Claimants	11 WC 4 WP 7	9 male 2 female	Range 26 to 53 Mean age 44.6*	10 JSA 1 ESA Duration- 6 months to 13 plus years	45-60 minutes	10 face-to- face 1 telephone
Work Programme healthcare professionals	3	1 male 2 female			60-90 minutes	3 face-to- face
Work Programme managers	4 WC 2 WP 2	2 male 2 female			30-60 minutes	4 face-to- face
Total	n=29					

NOTE. * Ten Personal Advisers and ten claimants provided their age. All of the healthcare professionals were senior practitioners (with more than five years' experience) and each had a different professional status. They had all worked in Pathways to Work Condition Management Programme. The Personal Advisers' work experience ranged from one to 19 years. Many of the Personal Advisers had worked in either recruitment, Jobcentre Plus, or for another provider organisation delivering employment support. One of the Personal Advisers had a dual role as manager. The managers' experience varied, for example, one had considerable experience covering more than fifteen years in the welfare-to-work sector and another had related experience in the same sector. Many of the claimants had recently claimed Employment Support Allowance or Incapacity Benefit and some had experience of the Work Capability Assessment. **Abbreviations:** WC- Work Choice, WP- Work Programme.

Table 4.6 Sample characteristics of 11 claimants who took part in semi-structured interviews

Participant identifier reference number	Self reported ethnicity	Self reported health condition	Sex
1	White British	Depression	Male
3	White British	Depression and anxiety	Female
4	Somalian	Depression and diabetes	Male
6	White British	Depression, anxiety and blood disorder	Male
11	White British	Depression and anxiety	Male
12	Asian Persian	Work related musculoskeletal injury-back	Male
13	Asian Persian	Arthritis and pain	Male
14	White British	Asthma and eczema	Male
17	White British	Terminal cancer	Female
18	White British	Cardiovascular condition and depression	Male
28	White British	High blood pressure /deaf	Male

Recruitment for semi-structured interviews

Programme managers, Personal Advisers and two of the healthcare professionals were initially recruited through their employer. One healthcare professional was recruited whilst being an informal informant. Claimants were recruited through provider organisations, or in the pilot interviews two cases through a PtW CMP.

4.5 Ethical considerations-procedural

The study received approval by the Research Ethics Committee at Sheffield Hallam University. This process involved providing an outline of the proposed work and completion of a project safety plan and risk assessment form. This risk assessment was particularly relevant given the study could involve vulnerable adults who may have limited mental capacity to give informed consent. I was also aware that a participant's capacity to give informed consent could change during the course of the study, especially if they had a fluctuating mental health condition or cognitive impairment.

Although two of the pilot interviews involved participants from the NHS PtW CMP, ethical approval from the NHS was not required because the study did not include NHS employees or NHS patients. The DWP was consulted at an early stage of the research, and it was concluded that the study did not require their approval. However, many of the DWP's ethical principles outlined in their guidance (Bacon and Olsen 2003) were applied to this study. Other guidance consulted during the study's planning and implementation phases included the American Anthropological Association (2010) and the British Psychological Society (BSP) (BPS 2009). This aimed to ensure that I was fully informed about issues such as confidentiality, informed consent and avoiding causing harm to any participants (BPS 2009).

4.5.1 Anonymity and confidentiality

Observation of the practice arena and 29 semi-structured interviews involved a small number of participants from three organisations within one locality. This raised concerns about protecting their identities. Bertram (2010) had similar concerns about how an informed reader could identify her study participants (advisers) through deductive disclosure of their traits and characteristics (Kaiser 2009). Therefore, she concluded that she would not document advisers' characteristics in her Thesis. In order to ensure all of this study's participants'

anonymity, I have summarised some of their characteristics as shown in Table 4.5. This summary allows the reader to have some background information about the participants without compromising anyone's identity. Thus, all verbatim quotes presented here only identify the participant in relation to their role i.e. Personal Adviser, claimant, healthcare professional or programme manager. To represent the sample, the quotes provided throughout this thesis have been selected from the majority of the participants who took part in the main study but not the pilot interviews.

4.5.2 Informed consent

Different strategies were required to ensure participants had provided informed consent and had opportunities to opt out of the study. When engaging in participant observation of the welfare-to-work arena, I made a conscientious effort to make my researcher identity and study overt at the earliest opportunity. Different approaches were required when gaining informed consent in practice settings. However, obtaining written informed consent from everyone was not possible, but I tried to ensure that people had the opportunity to be made aware of my presence by displaying a study poster and brochure at accessible places within the observation environment. The poster provided details about the study and included my photograph and university logo. When on site I also wore a first name badge displaying the university's logo.

Written informed consent from staff who were employed within the three sites was achieved through face-to-face meetings. Prior to observing Personal Advisers' one-to-one sessions I had the opportunity to talk to claimants in the waiting area and discuss the study and consent form, or if deemed more appropriate, the Personal Adviser would inform a claimant and seek their verbal informed consent for my observations. In some of these situations, I was then given time to talk to claimants and gain written informed consent before their appointment started. I tried to be vigilant to any participants who might feel coerced into taking part and be sensitive around any issues of power for example, by making sure that Personal Advisers gave ongoing verbal permission for my observations and interviews.

Obtaining informed consent from the participants who took part in a semi-structured interview involved providing a copy of the study information and consent form giving time to consider. Participants were asked if they had any

questions before this was signed and their interview started. Participants were also made aware that they could withdraw from the study during, or at the end of an interview. The consent form included permission to use anonymous verbatim quotes, therefore, participants were informed that after the transcripts were made available, there would be a restricted timescale where it would be possible to withdraw data from the analysis, presentations or papers.

4.5.3 Prevention of harm

Participants were informed that they did not have to answer any questions both in informal type conversations and semi-structured interviews. Whilst it was not my intention to ask claimants sensitive questions in open plan environments, some claimants did disclose personal information. In formal interviews participants were informed that they could stop their interview or have a break at any time. A debriefing sheet, which had contact details for support services, was given to claimant participants at the end of their interview. When transcripts were returned to participants (claimants) for any feedback, I pre warned them that they may find reading their accounts upsetting.

4.5.4 Data storage

Participants were informed about how their data would be stored and destroyed, and that any access to their transcripts would be made available to the supervisory team with their permission after personal details had been removed. All data was kept in a site file throughout the study either in hard copies in a locked file and /or encrypted IT system which met data protection requirements. Participants' personal and identifiable details were cleansed from the data and replaced with a reference number and site location. Interview recordings will be deleted to comply with data protection once the study is completed.

4.5.5 Ethics in practice

Ethics in practice involves addressing issues that arise during the study that were not necessarily considered during the ethical approval stage (Guillemin and Gilliam 2004). Given this study involved human service encounters, it was expected that I would not be able to pre-empt and anticipate all the problems that would be encountered, or outline all formal procedures prior to entering the field (Spencer 1993). Therefore, there were many examples where I needed to be responsive. For example, one interview participant requested a second

interview to disclose a personal experience that he had rarely shared. I discussed this with the Universities' Research Ethics Committee and supervisor. In this case, I offered the participant a follow up interview. However, as this participant was unable to attend two appointments offered. I discussed other ways in which he could access support.

4.6 Data generation and management

4.6.1 Participant observation of the welfare-to-work arena

As well as selecting key informants, I engaged in '*mixing and mingling with everyone*' (Fetterman 2010, p35) who had relevance during the early study stages. Table 4.3 in the above section, presented details about who was approached, or had involvement during the initial and ongoing study period (September 2009 to June 2013). Maintaining regular contact with key informants and developments in the field provided the added advantage of identifying and following key elements of the evolving landscape. This information enabled refinement of the research questions and design (Thomas 1993, Carspecken 1996). An alternative methodological approach may not have provided such multiple stakeholder views. Adopting a holistic approach also facilitated my knowledge about which data might be complementary and suitable for integration and synthesis (Mason 2002). For example, I became aware of the Work Programme bid documents whilst following an internet forum for claimants. These documents were then analysed and integrated with the new empirical data as shown in Chapter Five.

Overtime I realised the value of becoming embedded in the welfare-to-work arena and how this was generating data, for example, through active engagement I was invited to formal meetings with organisations including the DWP, local NHS organisations and a Local Authority. Additionally, these activities identified several key informants who provided ongoing involvement. For example, one key informant attended and provided feedback at my first PhD presentation, in line with the university's doctoral regulations, in January 2011. In addition, informants supported the refinement of my analysis as described in Chapter Six. Where possible handwritten notes, sometimes quite brief, were made during observations and later expanded, especially for pre planned informal interviews. However, it is important to note that making notes during these conversations, particularly at the early stages of the study, or when

meeting someone for the first time, it was not felt appropriate. It was also considered to risk the informal nature of the conversation. Therefore, in these situations it was common to have to rely on my memory which did limit full recall.

4.6.2 Observation of the practice arena

The fieldwork observations took place between October 2011 and November 2012. When entering the field I typically wore semi-formal dress to fit with the provider organisations' dress code. However, I reflected whether this would be a barrier to claimants if they perceived me as siding with a provider organisation. To counter balance any effect this might have, I tried to sit in a neutral place during observations which involved Personal Advisers and claimants. However, this was not always practical, and typically I sat next to claimants. Whilst observing I tried to cause the least disruption to Personal Advisers' work demands and interactions, and intended to be a non-participant observer. In practice, participants responded to my presence in different ways. For instance, some would try to include me by giving regular eye contact or asking me a question. Overall I found that it was easier recording observations when I was sitting in a neutral place. An example of this is provided in Chapter Seven in Box 7.1. However, sitting in a neutral place caused difficulties, for example, in not being able to hear a conversation sufficiently, especially if a Personal Adviser was speaking quietly to protect a claimant's confidentiality. Therefore, I was not able to record some data. Other observational events included sitting in waiting areas, and this provided opportunities to engage in informal conversations with claimants and gain further insights into their experiences. Prior to entering the field I explored a variety of methods that I could use for recording observations, such as, predesigned checklists, (Spradley 1979) diagrams and different categories of notes: substantive, methodological and analytical (Burgess 1984).

My first observations did not have a formalised format which is in line with Carspecken's (1996) approach. However, as the field work progressed, I typically followed a more structured format for observation as advocated by Carspecken (1996) and Fetterman (2010) which was supported by forms that I had designed. Example extracts of my fieldwork diary notes are provided in section 4.7.3. While in general note taking appeared to fit with the welfare-to-

work context and not look out of place, there were instances, during informal 'conversational type' interviews where note taking was less acceptable, or as Spencer (1993) highlights, could be insensitive and interrupt the casual nature of the conversation. Therefore, making detailed written notes was not always possible, and I used 'condensed notes' (Spradley 1979, p75) to capture the essence of what was taking place. Further expanded notes were written, were possible, at the end of the day and later typed and inputted into a software package, NVivo (2011). Digitally recording situations is likely to have been a more accurate method for recall. This option was explored, but only conducted on one occasion because it was typically inappropriate or not possible.

Following leads of inquiry

There were many occasions when I wanted to ask participants questions about my observations as '*... meanings, background experiences and emotional currents may not be directly expressed (...) in particular interactions*' (Emerson 2009, p536). However, this was not always possible in practice because of Personal Advisers' work demands, time constraints and the open plan office environments which prohibited privacy. Therefore, I sought further understanding through more formal follow-up interviews and/or member checks. One such example is given in Box 4.2. This shows an extract from a follow-up interview with a claimant. Here, I asked about the complimentary comments he had given to his Personal Adviser during his one-to-one session. This example illustrates the value of conducting retrospective follow-up interviews to gain a better understanding about how both claimants and Personal Advisers perceived their interactions and constructed meaning.

Box 4.2 Example extract from a transcript of an interview with a claimant

Interviewer: I remember you saying to [your Adviser], it was something along the lines of you've helped me more in the last 10 minutes...

Respondent: that's right, yeah than anybody else has in, in the past 13 years, I got more help off, like you say, more help in the first 10 minutes, quarter of an hour of that interview than I've had in the past 13 years off of, well, one, two, three, four, five, about six different advisers, about, well five probably, three at Jobcentre, one at [name of provider organisation] and then the one at [name of provider organisation], and add all them together over the past 13 years I got more, she helped me more in the first quarter of an hour, you know, with writing a list, see what you could do, (...)

4.6.3 Semi-structured interviews

This section describes how the 33 semi-structured interviews with 13 claimants, 13 Personal Advisers, 3 Work Programme healthcare professionals and 4 programme managers were designed and conducted. This description includes the four pilot interviews.

Planning and preparation

The interviews involved considerable preparation, which included scheduling time and venues, as well as preparing interview topic guides. Topic guides were produced to be used as a memory aid, to ensure that I followed different lines of questioning in response to participants' accounts (Thomas 1993). These incorporated ethnographic interview type questions which were descriptive, and open to allow participants to talk quite broadly about their views (Spradley 1979). Examples of interview questions are provided in Boxes 4.3 and 4.4.

Interview guides were revised after the pilot interviews were conducted, ongoing analysis, and further observations. The restricted time frame for some of the Personal Adviser interviews meant that only key questions could be asked. A diagram of a generalised claimant's Work Programme journey, (that was conceptualised as part of the documentary analysis presented in Chapter Six, Figure 6.2), was used in some of the interviews involving healthcare professionals and managers as an aid for probing for information. This diagram was also checked for accuracy.

Box 4.3 Example interview question

(Grand Tour type informed by Spradley 1979)

Interviewer: Can you describe what happened in that session when you first went?

Respondent: (Claimant): Yeah (name of Personal Adviser) didn't think basically that I were ready for work, she were really, she weren't really positive about it really umm she didn't think I was fit for work and didn't want to put me on the programme if I wasn't fit for work, she were really apprehensive about starting me at all

Interviewer: Umm

Respondent: but I had to explain that I were fit to do it and that if I didn't do it I would just get a lot worse

Interviewer: Right ok

Respondent: but, and I had actually been found fit for work by a tribunal

Box 4.4 Example question: asking a healthcare professional about what sorts of things claimants say about Personal Advisers

Interviewer: oh that's, that's interesting then, and, and if, when (claimants are) talking about Personal Advisers, what other things might they actually say about that relationship or that encounter with that Personal Adviser?

Respondent: sometimes, I've had a couple that, to be fair, have said they've been absolutely brilliant, they've done, you know, especially say like (name of programme) advisers and stuff, they've been really really supportive, have got them access to loads of things, I had one chap the other day that said if it hadn't have been for (name of programme) putting him in touch with (name of organisation), putting him in touch with us, he wouldn't know what, he said he just didn't realise there was that much support out there, so he's having a really good experience of it, whereas other people, again it's been often quite negative, in as much as, you know, I just have to go in, tell them what jobs I've applied for or not, and that's it, but don't seem to know what else is available I guess.

Personal Advisers

Appointments were scheduled with managers/senior Personal Advisers or directly with Personal Advisers. The time made available differed between 30 and 60 minutes. All but two of these interviews took place at Personal Advisers' usual place of work and were conducted face-to-face in a private or semi-private room, usually centred near a desk. One interview took place at an external venue at the request of the Personal Adviser, and one was conducted over the telephone because the Personal Adviser had changed jobs and location. Several of these interviews were disrupted, for example, with colleagues entering the room with a request for information. This may have limited the quality of the information provided. All of these interviews were digitally recorded, and one Personal Adviser requested an 'off the record' conversation. This data has been excluded from the thesis. In general, few if any notes were made during these interviews. Interviews involving managers and healthcare professionals followed a similar format as described for the Personal Adviser interviews, except one healthcare professional was interviewed at an external university venue. Two of these interviews also involved 'off the record' discussions.

Claimants

All but two of the interviews were conducted face-to-face in a university venue. One interview took place in a provider organisation's facilities, and one was conducted over the telephone at the request of the participant. Irvine's (2010) Telephone Interviewing Tool Kit was helpful in preparing for this interview. Participants were asked if they would like to be met prior to the interview at a place near the venue and escorted to the interview room. Participants were offered a drink, and the study information and consent form were discussed and signed. All but one of these interviews was digitally recorded. One was not recorded at the request of the participant. Therefore, hand written notes were taken, which may have limited the data collected. When concluding the interview, participants were asked if they had any questions and a debriefing sheet with health support contact numbers was offered. Care was taken to ensure that participants were not upset by anything they had shared during the interview. In line with DWP's guidance, participants were then reimbursed for their travel and a high street voucher of £20.00 was offered as a thank you for participating (Bacon and Olsen 2003). However, it became apparent that some

claimants were disappointed when I presented the voucher (selected by the university) because it was not suitable for their needs. Therefore, I decided to seek permission from the university to provide £20.00 in cash instead. This was agreed, and a formal system of recording was implemented.

Participants were offered to be escorted back to the meeting place, and all but one the participants requested this. Escorting participants to and from the venue was found to help build rapport and put participants at ease. This process also provided additional insights into participants' experiences, which were often shared, when the digital recorder had been switched off. Before leaving the participant, I initiated informal conversation that was unrelated to the interview as a way to close the interaction.

Completing these interviews was not straight forward. For example, many participants did not attend their initial appointment and other appointments were then given. Non-attendance could be challenging because of the time, in arranging and preparing venues, and waiting at the agreed meeting place. This reduced the numbers of interviews that could be conducted and data collected. I tried to be sensitive and reassure participants that it was not a problem, and check if they still wanted to take part. Reasons given for non-attendance included: forgetting the day and time, not being well, not having any money to pay for travel upfront, having to commit to job search activities, having a hospital/GP appointment, or deciding that they no longer wanted to take part. These conversations provided opportunities to build rapport with several participants, and two agreed to have further phone calls over a period of a few months to gather more data about their Personal Adviser experiences. Ongoing verbal consent was sought to make notes from these telephone conversations.

Leaving the field

When periods of field work observation were completed I formally thanked the participants where possible and left a small thank you gift for the team. An email was also sent to the manager to formally thank the teams' involvement.

4.7 Data analysis and interpretation

This section describes how the data generated from three methods: participation in the welfare-to-work arena; observation of the practice arena covering three sites; and 29 semi-structured interviews was analysed. The

process applied closely adhered to Miles and Huberman's (1994) data reduction, data display and conclusion/verification drawing stages. This was an iterative process as data was gathered while the analysis was initiated. Two analysis techniques were used: i) Spradley's (1979) ethnographic domain analysis techniques helped to support familiarisation of the data and gain initial insights. ii) Thematic analysis, both inductive and deductive (Fereday and Muir-Cochrane 2006, Braun and Clarke 2006) which is described in Table 4.7. The data gathered from the four pilot interviews followed a similar pattern of analysis as described above, which helped to inform the main study.

Table 4.7 Analysis process

Phase	Description of the process undertaken	Other activities undertaken
1. Familiarize yourself with the data:	Transcribing and reading transcripts to check against tapes, memo writing.	Spradley's (1979) domain analysis techniques.
2. Generating initial codes:	Preliminary manual coding of text: words, sentences and/or paragraphs. Using a prior and identifying in vivo codes using a systematic approach. Checking and defining codes for accuracy across the data set in NVivo. Combining or discarding codes.	Checking for respondent validation during ongoing semi-structured and informal type interviews. Memo writing and being reflexive. Maintaining an audit trail.
3. Searching for themes:	Asking questions about the data in relation to the research objectives. Conceptualising themes by gathering codes together using mind maps in Inspiration software package. Adding text from raw data.	Discussing the process and preliminary findings with the supervisory team. Peer debriefing.
4. Reviewing themes:	Ensuring themes reflect the data set by reworking themes where necessary.	Triangulation of data sources: reviewing notes and memos from all observations including participation of the welfare-to-work arena notes. Exploring any contradictions in the data.
5. Defining and naming themes:	Refining of themes and definitions.	Discussing progress with the supervisory team.
6. Producing the report:	Selection of verbatim quotes and field note extracts to illustrate themes.	Ensuring participants' confidentiality and anonymity and representation of the whole data set.

Adapted from Braun and Clarke (2006, p87) with reference to Mays and Pope (2000).

4.7.1 Data reduction

The handwritten and typed notes from the participation observation of the welfare-to-work arena and other collected documents were regularly referred to throughout the study and analysis stages. Some notes were typed and highlighted (using the reviewer comments facility in Microsoft Word) to label sections of text that could be linked to codes. An example of this is shown in Box 4.7 in section 4.7.3. Other documentary data, e.g. leaflets, copies of Work

Capability Assessment reports and any diagrams made during fieldwork observations were kept in files or notebooks.

The entire interview recordings were transcribed verbatim, 27 by an external university approved transcriber (with participants' permission), and five by me, the first four pilot interviews and one at the request of a participant. All transcripts were then checked against the original recording for accuracy. Memos were written after conducting each interview and whilst listening to the digital recordings after transcription. This activity encouraged further reflection, and identified more questions that could be asked in further interviews. Anonymized transcripts were then made available to each participant. Not all participants wanted a copy. Only one participant made contact after receiving her transcript to request certain quotes were removed and/or reworded. This participant stated she felt she had spoken negatively about her experiences and Personal Adviser while having a difficult day. This request revealed how a participant could alter and reconstruct their interpretations of their interactions with a Personal Adviser over time. This is highlighted in Chapter Seven. The anonymized transcripts were then entered into NVivo (2011).

The next stage involved becoming familiar with the data and Spradley (1979) identifies a number of ethnographic analysis techniques that were helpful at this stage. One of these explores how participants express semantic relationships. By using a universal semantic relationship, (for example, to identify a strict inclusion - X is a kind of Y), I was able to start to understand aspects of Personal Advisers' practice. Figure 4.4 provides an example of how I applied this technique to analyse an interview transcript to see what might be involved when a Personal Adviser assesses a claimant.

Figure 4.4 Semantic Relationship

Form: X is a reason for doing Y

Example: A Personal Adviser conducts different assessments to understand a claimant's difficulties

Included terms	Semantic relationship	Cover term
<i>"induction process"</i>		
<i>"give different tasks"</i>		
<i>"sit with them"</i>	is a kind of way	<i>"get to know her"</i>
<i>"in-house sessions"</i>		
<i>"observe"</i>		
<i>"try to get it out of them in the initial interview"</i>		

Adapted from Spradley 1979, p 182

Coding

The next stage of analysis involved coding the data. This involves assigning labels of meaning to sections of the text (words, sentences paragraphs) which can be descriptive and inferential (Miles and Huberman 1994). Prior to coding, fieldwork notes and transcripts were reread to ensure familiarity. Coded text included words, a sentence or paragraph and some sections of text were coded more than once. For the deductive coding, an a priori code list (including the eight Personal Adviser role dimensions identified in Chapter Five, and illness and wellness perspectives informed from the theoretical framework developed from Chapter Two) was used. Inductive coding was used to explore conditions, interactions amongst actors, strategies and tactics and consequences as suggested by Miles and Huberman (1994) with reference to Strauss (1987) and

identifying in vivo codes. Initially the data was coded manually, but was completed with a computer assisted software programme, NVivo. Although I had completed a two day NVivo training course, some time prior to coding the data, I was concerned that I might not be competent with this and "over code" the data. Therefore, NVivo was most useful for data management purposes and to revise and check code consistency, although some electronic coding, note annotation, and memo writing was carried out using this software. Examples of how coding was conducted are presented in Table 4.8.

4.7.2 Data display

A software package, Inspiration (2012) was used to explore and mind map the relationships between codes. Mind mapping is suggested as a suitable technique by Braun and Clarke (2006). The Inspiration software was helpful because it incorporated text. Therefore, I was able to link raw data to the codes and emergent themes in a visible format. Drawing on different analysis approaches was considered to be creative, and to support conceptualisation of meaning (Miles and Huberman 1994, Kvale and Brinkmann 2009).

4.7.3 Conclusion drawing, verification and ensuring trustworthiness

There is much debate in the qualitative methodology literature concerning the way in which research can be deemed to be of good quality (Marshall and Rossman 2010 and which assessment criteria should be applied (Finlay 2006). While quantitative research focuses on reliability, validity and generalisability, these concepts do not fit as well within the qualitative tradition (Finlay 2006). Instead other criteria have been proposed, for example, Lincoln and Guba (1985) propose: credibility, transferability, dependability and confirmability criteria. However, these criteria has also been criticised for reflecting positivist traditions (Spencer et al. 2003). Therefore, when selecting quality criteria the researcher needs to justify their choice to enable a reader to assess a study's quality and claims (Finlay 2006). This requires providing '*... thorough, careful, honest and accurate...*' (Mason 2002, p188) accounts, not only about the process of generating and analysing the data (Mason 2002) but demonstrating how the researcher has been reflexive. Of importance in this study, is whether the claims are plausible, and able to contribute (Hammersley 1992) to our understanding about Personal Advisers' practice and are transferable to a different context and setting. One way a reader can judge if this is possible is by providing a thick description (Lincoln and Guba 1985) of the context. However, the ways in which the descriptions have been gathered also need to be credible.

I will now describe my approach taken to ensure quality which draws on different elements of criteria that fit with my epistemological position. The findings of the new empirical data are intended to represent the realities of the

research participants 1..*rather than to attain the truth...*' (Mays and Pope 2000, p51). Some of the activities undertaken have already been outlined in Table 4.7. Before the conclusions were drawn, I reviewed and refined the themes through discussion with my supervisory team. These meetings were especially valuable as the research was conducted independently. I also explored the data for any contradictions (Mays and Pope 2000) and thought about the use of participants' language to describe their meanings, and how my interpretations might be understood when I was seeking validation. Triangulation of data sources is indicated to support the study's quality (Fetterman 2010) by using different data sources to corroborate interpretation (Mays and Pope 2000). Box 4.5 provides an example to highlight how two informal type interviews with two JCP employees generated data which collaborated the way in which Personal Advisers' accounts (provided in their semi-structured interviews and observations of their practice) indicated that they adopted a health monitor role as described in Chapter Seven.

Box 4.5 Example of triangulation of data sources to corroborate the health monitor role

Informal interview with a Jobcentre Plus (JCP) manager to gain information about the new sanctions regime:

During this meeting I asked about what JCP Personal Advisers did when they thought a claimant was at risk of self-harm. The manager explained that there was a national protocol for Personal Advisers to follow and that this had been adapted locally.

Fieldwork notes: Location: Jobcentre Plus office

Informal interview with JCP Disability Employment Adviser (DEA):

The DEA explained that if she had concerns about a claimant's health in relation to self-harm, she would contact all of the GPs in close proximity to where that claimant lived and leave a message expressing her concerns. Personal Advisers do not have claimants' GP details.

Fieldwork notes: Location: provider organisation network event

Introduction and group discussion with team of Work Programme Personal Advisers:

A Personal Adviser briefly talked about a claimant who had expressed suicidal ideas.

Fieldwork notes: Location: Site Four prior to withdrawing further support

Note: This fieldwork note also linked to an in vivo code: '*suicide watch*' which was identified in the semi-structured interview data.

Respondent validation can validate a researcher's interpretation by checking with others, who are considered to be in a position to do so because of their experiences (Mason 2002). However, there are draw backs with this approach as it assumes that certain people have a '*kind of epistemological privilege*' (Mason (2002, p192) and others' interpretations may also differ to those of the researcher (Rock 2001). Therefore, its use needs to be considered carefully and has limitations (Mays and Pope 2000). During interviews (both formal and informal) I used respondent validation as a technique to check my initial interpretations from fieldwork observations and semi-structured interviews. An example of respondent validation is shown in Box 4.6. This contains an interview extract where I asked a Personal Adviser about a monitoring role. Another example involved returning to a provider organisation after my initial observations to talk through my preliminary analysis with the team members. Although this activity did not identify any disagreement with my initial interpretations, I was cautious that the participants may not feel comfortable challenging my preliminary findings. Furthermore, presenting interpretations in a group situation could also risk participants being subject to Group Think and agreeing to the information presented (Janis 1972) as suggested by Lincoln and Guba (1985). Therefore, this activity was considered to add further data, rather than validating my findings (Mays and Pope 2000).

Box 4.6 Example interview question: checking if a Personal Adviser engages in any form of health monitoring

Interviewer: Have you got any examples where you've become quite concerned about somebody's health and well-being?

Respondent: I'm trying to think, there's, I can't think of anything where I've necessarily been worried about their health, but sometimes obviously going into the situation and the employer might think they're getting on really well or vice versa, and you know, you might just go and observe them a little bit at work and see how it's going, and you know, you might actually notice that they do seem to be struggling with something, or you know, whatever it is, or the job role's not what it originally was when I saw them two months ago or whatever it is, so there has been instances like that, but actually thinking of health, (...), quite a recent case I've been asked to go in and kind of look at somebody's role, because the employer feels like he's no longer able to do the role, and obviously they wanted to seek advice and someone else's, you know, kind of support on that, and actually you know, shadowing him in his job I would probably agree that for his health he isn't doing himself any favours and he's having to lift quite heavy things and his, you know, his mobility's not very good, and you know, I can see the dangers that are potential there, so you know, obviously I would share that back with the employer.

Peer debriefing can be useful to alert a researcher to any potential bias (Lincoln and Guba 1985). I engaged in a range of formal and informal debriefing type activities. For example, I regularly discussed my work with an ex colleague who was also a healthcare professional with experience of working with Personal Advisers and claimants. This enabled further reflection about whether my findings were *determined by the subjects (respondents) and conditions of the inquiry and not by [my] biases, motivations, interests, or perspectives...*' (Lincoln and Guba 1985, p290). These types of conversations also challenged my thinking and made me more alert to the ways in which interpretations of the same events can differ and be explained.

Strategies to support reflexivity throughout the research process included the following:

- Keeping a research diary to document and reflect on ideas, my role and potential bias within the study. But it is acknowledged that engagement in this activity could have been more disciplined and frequent at times. Box 4.7 reveals some of my early thinking about the study, and Box 4.8 contains example extracts of my analytical field notes completed during observation of the practice arena.
- Preparing and reflecting on study presentations both internally at the university and external events.
- Reflecting on the research process during supervisory meetings.
- Engaging in peer discussions, for example, whilst completing university masters research modules (methods, ethics and philosophy) and informally when debating/analysing the research methods and findings.
- Ongoing discussions with the university's Research Ethics Committee to ensure that the best ethical procedures were in place and to resolve ethical dilemmas encountered in practice.

Box 4.7 Research diary extract written at the start of the PhD- reflexivity and positionality

(11.11.09) Leshem and Trafford's (2006) paper on reflective practice during post doctoral research was inspiring. It makes me see the value of ensuring I learn as many skills as possible by keeping a reflective log throughout my PhD. I need to give myself permission not to feel self indulgent in taking the time to document my past experiences as new knowledge could be gained from this process. (...). But the more I read the more I became acutely aware of what I don't know. I tell myself this is ok and that my journey here is to learn, and have time to do this is the norm. In the DWP world this would be termed 'distance travelled'. I feel closeness to this, and want to capture my own distance travelled so I can see progress.

At this early stage I am particularly interested in understanding (...) what had led me to take this route? Why is it important and interesting? Where am I positioning myself and what are my perspectives about the people I will be studying? I wonder how my experiences and knowledge sit in relation to this. (...). I also want to park my own experiences and wonder if this is the right thing to do. Am I concerned I would not be objective? Bias? In my work as a therapist I could be detached from my personal experiences when working with a client. Could, and should this be the case in my research?

I feel I need to explore my emotional side of my experiences in order to somehow protect my studies from my personal influences. Yet some of my personal experiences have been positive when exploring research questions. So I am ambivalent about the value and significance of my past.

(02.07.13) *Reflection whilst revising this chapter:* I find my use of the DWP's language terms interesting and a bit odd. But I think this reveals something about my familiarity and connection with the welfare-to-work field at that time.

Box 4.8 Extracts of my analytical diary field notes

Fieldwork notes: Being directive: 17.09.12 (after observation of the practice arena)

The Personal Adviser (in the job club) appeared to be quite directive about clients making changes to their CV's. This was in contrast to the other provider who negotiated changes. Some Personal Advisers advise, suggest, tell or instruct claimants. Where do mandatory powers come into play here? I have not seen any evidence of mandatory powers yet.

Memo: Fixing the system 26.09.12 (after observation of the practice arena)

Should Personal Advisers' time be spent on helping those with employment stuff rather than appeals following their WCA?

Memo: Shift in health perception 8.08.12 (after a phone conversation with a claimant)

This conversation was quite different to the way in which the client appeared to feel and speak about her experiences when she was observed in the job club recently. At that time she appeared very enthusiastic and keen to start a work placement. This raises questions about how clients manage setbacks and build resilience for any disappointments. How can claimants be supported to manage their anxiety and depression better? I wonder whether this organisation addresses claimants' anxiety issues concerning job interviews. This client's account clearly identifies a health-related support need and benefit of a CMP type provision. GP services may not have access to an integrated health and work related support provision.

Further details about the methods that have been employed will be described in subsequent chapters to aid the readers' comprehension. Chapters Six and Seven draw on several parts of the data¹¹ and Chapter Eight integrates the findings (from the various layers of ethnography) to answer the nine research questions and produce wider claims.

4.8 Conclusion

This chapter has explained that this multi-layered ethnographic study aimed to explore welfare reform policy and how Personal Advisers' practice supports claimants who have long-term illness. It has outlined the research objectives and questions and described why a qualitative methodology, drawing on ethnographic principles was selected. The ethical procedures and ethics in practice considerations have been described. The analysis process and interpretation of the new empirical data has been shown, in addition to providing a reflexive account of the research processes. The following chapter is the first of three findings chapters. This reviews how the Personal Adviser's role has

¹¹This data relates to the Coalition government's reforms.

previously supported claimants with long-term illness prior to the introduction of the Work Programme policy.

Chapter Five: A theory driven review of how welfare-to-work Personal Advisers have supported claimants with long-term illness on their back to work journey

5.1 Introduction

This chapter is the first of three findings chapters which aim to investigate the support that claimants with health conditions have received within employment support that is contracted out and overseen by the Department for Work and Pensions' (DWP), and the role of the Personal Adviser. This first chapter looks back at what has already been documented about the role of the Personal Adviser through a theory driven review of employment support delivered prior to the launch of the Work Programme. This is important because, as shown in Chapter Three, Personal Advisers have been expected to play a crucial role in supporting claimants into paid work, but have also been found to struggle to support some claimants with long-term illness. Additionally, this review asks questions that are likely to have relevance for today's welfare-to-work context (i.e. the Work Programme policy) and the findings have usefully directed the focus of my inquiry concerning employment support which is described in Chapter Six and Seven.

This review contributes to answering the following research questions:

Micro-level

7. What types and variations of health-related support do claimants access from their Personal Adviser?

8. What strategies do Personal Advisers adopt within their practice involving claimants with health-related needs?

9. What competencies does a Personal Adviser need to support their ways of working with claimants who have health-related needs?

The chapter begins by outlining the theory driven approach that was adopted for this review which was described in Chapter Four. The four stages of the review are then described in turn. The first stage outlines the identification of the 'programme theory' - in the form of propositional statements - before moving on to stage two. This section details the comprehensive search, appraisal of the literature and extraction of the relevant data to test the propositional statements. The synthesised findings are then presented, and a discussion of the findings in relation to the four propositions follows. Finally, the chapter concludes by highlighting what has been found out in terms of the context influencing Personal Advisers' interventions and outcomes. It also considers how the findings might be relevant for Personal Advisers' practice within the new Work Programme and other programmes, such as Work Choice, which aim to support claimants who have health conditions.

5.2 Stage one: identifying programme theory

A theory driven review drawing on a realist approach was adopted. This was guided by Pawson et al.'s (2004) approach that was outlined in Chapter Four. The principles of a realist approach were relevant and useful to help answer the objectives because evidence could be reviewed and synthesised to gain an understanding of the interaction between the context, mechanism and outcomes (Wong et al. 2010) that characterised the practice of Personal Advisers. This approach is relevant and useful in helping to answer the research questions because it assumes that the provision of successful interventions relies not only on the behaviour and abilities of the actors involved but the influences from the structures in which they operate (Pawson et al. 2005). Thus, this approach allows an exploration of why and how Personal Advisers have responded to claimants with health conditions, in different contexts and programmes, in order to address their barriers to work. In addition, it can explore the ways in which Personal Advisers operated and responded to helping claimants.

In order to identify the underlying rationale and assumptions of Personal Adviser interventions, an exploratory literature search was conducted. This involved an initial web-based search to identify: policy documents; welfare-to-

work programme evaluations; audits of the Personal Adviser role; and papers researching and discussing welfare-to-work programmes. Literature sources that were included are listed in Figure 5.1 Jobcentre Plus was also contacted by email in July 2010 and a request was made for any internal evidence about the Personal Adviser's role. Descriptions of the Personal Adviser role were provided by a branch manager. The definition of "Personal Adviser" employed here included frontline staff delivering employment support programmes prior to the launch of the Work Programme policy. An exploration of both the explicit and implicit underlying assumptions about the Personal Adviser's role was undertaken, in order to develop an understanding of the programme theory, which is how the intervention is hypothesised to operate in practice (Pawson 2006). Reading of the identified literature revealed explicit Personal Adviser role definitions, for example, the key areas of Personal Advisers' practice were described in the National Audit Office (NAO)'s (2006) report as shown in Box 3.2. The policy document analysis (Table 3.1 in Chapter Three) also explored how the role of the Personal Adviser was framed. Exploration to identify what Personal Advisers have done within their interactions with claimants was also undertaken. Thus, the organisational context in which Personal Advisers have been situated, the way in which they delivered services to individuals, how their interventions were supposed to work, and the mechanisms of change to achieve the expected outcomes for claimants were considered.

Personal Adviser interventions have been based on personalised support, which aims to increase claimants' 'employability' (Clayton et al. 2011). One of the main mechanisms that Personal Advisers have used as a vehicle for facilitating claimants' progress is the Work Focused Interview (WFI) which was discussed in Chapter Three. A WFI has generally been conducted face-to-face and arranged at set intervals over a period of time. There has also been an expectation that individuals will engage in work-related activities. Once agreed, these activities have typically been documented by a Personal Adviser in an action plan and there has been an expectation that a Personal Adviser will take into account any health-related barriers to employment that a claimant may have (DWP 2006a).

Figure 5.1 presents the model that was constructed to conceptualise how the programme theory is intended to work. This theory assumes that claimants will

engage in this two-way process and establish a productive relationship with their Personal Adviser. The Personal Adviser is expected to get to know the individual in order to be able to identify any barriers to employment, including health-related issues. This detailed understanding is then expected to help to ensure that the decision-making practice is appropriately tailored to the individual's circumstances. The Personal Adviser may also employ interventions that influence the employment environment (Clayton et al. 2011). Five key assumptions underpinning the programme theory were shown to be:

- One-to-one input will provide a space and relationship within which claimants can identify and be supported to address barriers.
- Personalised inputs allow support to be tailored.
- Continuity of the Personal Adviser role builds trust and rapport.
- Case management enables coordination of an individual's journey into work.
- Personal Advisers have the health knowledge required and are confident and able to identify the right support to address individuals' health-related barriers.

These assumptions were refined to form four propositional statements that were felt to be core to the programme theory. These propositions were then tested and refined at the second stage of the review. These were:

- I. A collaborative relationship between the Personal Adviser and the claimant will be developed and will support progress towards getting into work.
- II. A balance between “enforcer” and “enabler” will be possible and will support progress to work.
- III. Flexibility and autonomy to respond to individual claimants will enable Personal Advisers to adapt and develop a personalised input.
- IV. Personal Advisers will be equipped and supported to fulfil their role in addressing claimants' health-related barriers to work.

Figure 5.1 Back to Work Support Model

Personal Adviser interventions

Back to work support



Claimant Journey

(Millar 2000, NAO 2006, DWP 2006, Vanstolk, Rubin and Grant 2006, Bunt and Maidment 2007, Sainsbury 2008, Sheppard 2009).

5.3 Stage two: comprehensive search, appraisal of the literature and extraction of relevant data to test the proposed theory (propositional statements)

The search was designed to identify studies that would provide evidence on ways in which Personal Advisers work with individuals with health conditions. 13 databases were searched for papers published between January 1998 and February 2011. These were: AMED, Assia, BNI OVID, CINAHL Plus, Emerald Management Xtra, Index to Theses, PsynInfo, Medline, Psych Articles, Science Direct, Sociological Abstracts, Scopus, and Web of Science. The following key words were used: Personal Adviser, Personal Advisor, Employment Adviser, Employment Advisor, Employment Coach, and Jobcentre staff, Jobcentre Plus, Benefits Office, back to work, unemployment, employment, welfare to work, illness, ill-health sickness and incapacity. A total of 12,989 studies were initially identified, as shown in Table 5.1, however the majority of these were excluded because they concerned studies outside of the UK, involved mixed groups of participants which did not fit the inclusion criteria or concerned Personal Advisers' roles unrelated to welfare-to-work. The inclusion criteria included all qualitative and quantitative UK studies with a publication date of 1998 onwards (the year when the Personal Adviser role was initiated) that were written in English. This included return to work studies of participants of working age (16-65) who were in receipt of welfare to work benefits and had a health condition/long-term illness with or without an impairment or disability. All studies that, related to people of working age who were out of work but not claiming benefits, or were not connected to a return to work provision were excluded.

Pawson (2006) recommends that a quality appraisal assessment should identify studies that can demonstrate relevance and rigour. To establish relevance each study identified in the search was screened by title and abstract if required. 190 of the retrieved studies met the inclusion criteria and were screened for relevance. Eight of these studies were identified as relevant to the review question. The remaining papers did not meet the criteria for example, the age range of the participants extended beyond 65, or the focus of the study was on other issues such as employers or employment services more generally rather than the Personal Adviser role. Papers assessed as relevant were read

in full and subjected to a quality appraisal assessment, following recommendations from Boaz and Ashby (2003). Further methodological details of the studies concerning two of the selected papers were sourced and checked for more detailed evidence before they were included in the review (Dewson et al. 2007, Grant 2011). All eight relevant papers passed the quality appraisal assessment and were included in this review. References of relevant papers were hand searched and citations of relevant papers were checked but no further studies were identified. An internet search identified twelve further relevant studies of adequate quality that explored the Personal Adviser's role, claimant's journey and health-related support. This inclusive search approach aimed to ensure that evidence from a range of different contexts, and a variety of Personal Adviser and claimant groups would be used to test the proposed statements. A total of 20 papers were included in the review. These are listed in Appendix 3. The majority of the studies used qualitative methods including in-depth interviews and focus groups. The quantitative studies used surveys. Eleven of these studies had an explicit focus on health. Seven of the studies included were commissioned by the DWP as part of a wider evaluation of the programmes involved. Ten of the studies included both Personal Advisers and claimants. Seven concerned only Personal Advisers or stakeholders who had been involved in delivering or managing provision and three involved claimants only.

Table 5.1 Search strategy for theory driven review

Database	Hits	Initial search suggested relevant
PsynInfo	5750	71
CINAHLPlus	3785	37
ASSIA	148	11
BNI OVID	78	1
AMED	796	21
Science Direct	184	5
Emerald	1320	7
Management Xtra		
Psych Articles	222	1
CSA		
SCOPUS	254	14
Web of Science	167	13
Sociological Abstracts	285	9
Index to thesis	2	0
Total	12989	190

N=8 selected for richness and relevance

The appraised studies were read and re-read and sections of the text were highlighted and coded as recommended by Pawson et al. (2005). Attention was given to information that could test the proposed statements. Recurrent themes were identified and a framework was developed to systematically record these themes with links back to the original text. The studies were read again at different stages of the review to confirm or challenge the themes identified and to explore any new emerging themes or questions.

5.4 Stage three: synthesis of findings

This section presents the findings which were synthesized to test the four propositions outlined in section 5.2 and explored to determine whether these needed to be extended.

5.4.1 Proposition 1: A collaborative relationship between the Personal Adviser and the claimant will be developed and will support progress towards getting into work.

Building a collaborative relationship with claimants was a core feature of a Personal Adviser's role that was identified in many of the studies reviewed (Knight et al. 2005, Dixon, Mitchell and Dickens 2007, Hudson et al. 2009, Green and Shuttleworth 2010, Drew et al. 2010, Macmillan Cancer Support 2010). While no evidence on the link between collaborative relationships and outcomes was found, some studies looked at claimant and Personal Adviser experiences and preferences of practice approaches. Developing a collaborative relationship has been shown to be of benefit and can be a crucial step to help manage claimants' fears and anxieties (Hudson et al. 2009), which have been shown to be common (Grant 2010), and to help develop trust (Green and Shuttleworth 2010). When Personal Advisers responded sensitively to claimants' health stories, this has positively shaped claimants' interview experience (Hudson et al. 2009). Therefore, adopting a counselling role dimension (described in section 5.4.3) and related activities may have supported a Personal Adviser's practice (Dixon, Mitchell and Dickens 2007, Hudson et al. 2009) and enhanced their rapport with claimants. The importance of this was suggested by studies in which claimants expressed their positive experiences of a Personal Adviser's counselling role dimension (Hudson et al. 2009, McNeil 2009, Macmillan Cancer Support 2010).

Factors indicated to play a pivotal role in helping to establish a good relationship with a claimant included the continuity of Personal Adviser (Knight et al. 2005, Nice, Irvine and Sainsbury 2009, Fletcher 2008, Hudson et al. 2009, Macmillan Cancer Support 2010). However, continuity has been disrupted through staff turnover (Fletcher 2008). Another important factor was linked to the freedom and flexibility Personal Advisers were provided in their practice (Green and Shuttleworth 2010), especially in deciding the amount of time that was made available for a WFI (Barnes et al. 2010). Having sufficient time could enable a Personal Adviser to engage in informal conversation which could help establish rapport with a claimant (Dixon, Mitchell and Dickens 2007). Additionally, one study reported that when a Personal Adviser shared personal information their service was perceived to be successful by claimants (Heenan 2002).

Action planning activities were recommended in the Labour government's policy as a means to gain claimants' engagement, through co-ownership, during WFLs (Gregg 2008, DWP 2008c) as shown in Chapter Three. However, there were variations in how action planning was approached by Personal Advisers, and not all claimants appeared to have received a copy of their action plan (Knight et al. 2005, Dixon, Mitchell and Dickens 2007, Hudson et al. 2009, Barnes et al. 2010), or remember having one (Dixon, Mitchell and Dickens 2007).

'I explain to them that the action plan is just one place on the computer system where everything we've talked about gets drawn together...We are supposed to print it out and give it to them but we tend not to, because they throw it away as soon as they go out through the door.'
(JCP adviser, District 1)

(Barnes et al. 2010, p33).

Two studies found that some Personal Advisers used action plans as a memory aid for their own record of a claimant's progress (Nice, Irvine and Sainsbury 2009, Hudson et al. 2009). One of these studies also highlighted that, on occasions, Personal Advisers might have made decisions on behalf of their claimants without seeking their views first (Nice, Irvine and Sainsbury 2009). Some Personal Advisers had referral targets for certain provision such as CMP, and some claimants reported feeling 'pressured' to accept this (Dixon, Mitchell and Dickens 2007, Hudson et al. 2009, Grant 2010, Nice and Davidson 2010). Therefore, it is unclear whether Personal Advisers' suggestions or recommendations about certain provision could undermine a collaborative relationship. Similarly, whether there were any issues of unequal power in these relationships and to establish the extent of 'true' collaboration. Hennan (2002) asserts that by adopting a rapport building approach, and sharing personal information, a Personal Adviser may reduce any unequal power in their relationship. However, as Hennan's (2002) study involved claimants who were volunteering in a programme, this assertion may not be transferable to claimants who were mandated to attend programmes such as the previous PtW or the new Work Programme. Issues concerning Personal Advisers' "powers" may become more pertinent in the new Work Programme when they are expected to have their decision making practices in relation to conditionality increased, as shown in Chapter Three.

Both Personal Advisers and claimants' accounts have revealed a number of factors which might undermine a collaborative relationship. These included factors which related to the organisational context and therefore, may not always be possible to change or be under a Personal Advisers' control, for example, a lack of privacy in WFI (when they take place in open plan offices) or having to answer the telephone whilst engaging with a claimant (Knight et al. 2005, Dixon, Mitchell and Dickens 2007).

'...because I just felt certain things we were talking about, I had to lower my voice, and I remember keep like looking around because there's a lot of people.' (Client 5, female, age 50s)

(Hudson et al. 2009, p42).

These contextual influences then limited what some claimants were willing to share with their Personal Adviser (Hudson et al. 2009).

5.4.2 Proposition 2: A balance between 'enforcer' and 'enabler' will be possible and will support progress to work

The two role dimensions of 'enforcer' and 'enabler' were clearly in evidence in both the policy documents that described how the Personal Adviser intervention should operate in theory and the empirical research evidence that documented how Personal Advisers were found to perform in practice. However, while there was strong evidence that Personal Advisers recognised these contrasting elements of their role, it was clear that there is considerable diversity in how they operationalized these elements in practice, and the extent to which they managed to adopt enabling behaviours. There was also evidence of varied opinions among Personal Advisers and claimants regarding the contribution of these, potentially conflicting elements, towards supporting claimants with health conditions into work. Therefore, it was not clear that a satisfactory balance between the 'enforcer' and 'enabler' role was always achieved, or that such a balance was appropriate for all claimants to make progress.

Enforcer

This role dimension concerns the way in which Personal Advisers decided to use their 'powers' to sanction a claimant who had not complied with the benefit entitlement regulations, for example, failing to attend their WFI. The studies reviewed highlighted that Personal Advisers had mixed views about the effectiveness of sanctions and how they should approach this aspect of their

role (Knight et al. 2005, Barnes et al. 2010). While some Personal Advisers commented that sanctions could be a motivator and enhanced claimants' engagement in programmes (Joyce and Pettigrew 2002) and attendance at WFIs (Dixon, Mitchell and Dickens 2007), others experienced tension and conflict between their 'enabler' (described below) and 'enforcer' role (Knight et al. 2005, Dixon, Mitchell and Dickens 2007, Drew et al. 2010). Differences in practice were also shown (in one study) to have an association with individual Personal Advisers' views about whether sanctioning a claimant who experienced ill health was morally acceptable (Knight et al. 2005).

There was some suggestion that Personal Advisers adopted strategies which corresponded to sanction guidance in order to avoid having to sanction claimants with health conditions (Knight et al. 2005, Barnes et al. 2010, Grant 2010). For instance, having a genuine health-related issue could be perceived as a 'good reason' for failing to attend appointments (Knight et al. 2005). Additionally, Personal Advisers' line managers' approach to sanctioning could influence their practice if they were directed to use sanctions as a tool to improve claimants' attendance rates (Knight et al. 2005). In contrast, another study, involving four districts, revealed that it was common for provider organisations to avoid sanctions to prevent any disruption to their relationships with claimants (Barnes et al. 2010). This suggests that the use of sanctioning may serve a different purpose at an organisational level, and may not necessarily correspond with a Personal Adviser's views or practice preference.

Enabler

Many of the studies which explored Personal Advisers' perspectives (in PtW) documented how this role aimed to help claimants to make progress towards working. For example, some Personal Advisers considered that some claimants, particularly those who had been out of work for longer periods, needed longer-term support (Knight et al. 2005, Dixon, Mitchell and Dickens 2007, Green and Shuttleworth 2010). Therefore, some Personal Advisers described this aspect of their role as being to "*sow seeds*" (Knight et al. 2005, p18) or to "*nudge people along*" (Green and Shuttleworth 2010, p239). These two studies revealed how Personal Advisers measured success in terms of the progress claimants made across a range of areas, for example, self-confidence, and not just by securing employment (Knight et al. 2005, Green and

Shuttleworth 2010). In addition, Personal Advisers tried to help improve a claimant's health despite perceiving they might not secure work (Dixon, Mowlam, Dickens 2007).

However, this tailored, person-centred approach required a detailed understanding and a trustful relationship, and the evidence suggests that some Personal Advisers struggled to obtain a clear picture of an individual's health condition and any related barriers to employment. Several studies found that problems in assessing claimants' health-related barriers could make it difficult to determine suitable work or appropriate intermediate steps, for example, in considering a Condition Management Programme (CMP) or to have productive discussions around work. Personal Advisers' abilities to identify suitable forms of work were indicated to be a challenging aspect of their practice.

'Establishing a job [goal] is quite difficult, and the WFHRA doesn't help us along those lines. If they can't go back to their usual occupation, what other occupations can they do?' (JCP adviser, District 1)

(Barnes et al. 2010, p28).

These challenges were also reflected in some claimants' views:

'I was very, very disappointed with the help I had to get back to work, erm, because it's like I said, all the jobs she kept giving me were jobs that I knew I couldn't even attempt to do, and she put me down for cleaning and I kept saying to her why are you giving me cleaning jobs. Then she said to me that she didn't know what else to put me.' [Female, 58]

(Patel, Greasley and Watson 2007, p835).

Another study showed Personal Advisers' perception of a claimant's illness, and imposed identity could influence the way in which certain types of work were then considered by Personal Advisers (Riach and Loretto 2009). This finding illustrated how Personal Advisers' views might conflict with a claimant.

"I went to a disability advisor [in the jobcentre] and they said that now you've got a slight disability as well there's no way you will expect to earn what you used to earn, you're going to have to downgrade. She actually suggested training to go and work as a care assistant ... I was so insulted". (Female, IB)

(Riach and Loretto 2009, p113).

In contrast, evidence in two studies showed how claimants did perceive suitable types of work were explored with their Personal Adviser (Heenan 2002, Grant 2010) which highlights how the experiences and expectations of claimants can differ, and how the abilities of Personal Advisers may vary.

Personal Advisers' struggles to identify suitable work may have implications for the 'seller' role dimension which is outlined below, particularly as being fearful of exacerbating an individual's health condition was a concern for some Personal Advisers (Dixon, Mitchell and Dickens 2007, Macmillan Cancer Support 2010). Drew et al.'s (2010) study also highlighted that some Personal Advisers did not fully engage or delayed providing advice and guidance on employment options for claimants with health conditions until they perceived they were well enough. In addition, the extent to which a Personal Adviser felt they could challenge individuals about their perception of their health and employability, for example, if a claimant's account of their health differed from their benefit medical assessment or other medical reports, is a pertinent question not readily answered through the review material.

5.4.3 Proposition 3: Flexibility and autonomy to respond to individual claimants will enable Personal Advisers to adapt and develop a personalised input.

Overall, there was strong evidence that Personal Advisers experienced high levels of autonomy and operated flexibly in many areas of their practice to develop a personalised approach to supporting claimants. This flexibility was clearly evidenced by the wide variety of role dimensions that they were found to perform in order to provide health-related interventions in their practice, in addition to their general 'enabler' and 'enforcer' roles already discussed. - At least six further role dimensions were identified in the literature, and these are each described below. However, the evidence also highlighted various ways in which this flexibility resulted in diverse practices, raising concerns about equity and the extent to which Personal Advisers managed to provide adequate and appropriate support to claimants with health conditions, as discussed in the sections below. Furthermore, the evidence also pointed to a range of individual and contextual factors that could hamper Personal Advisers' ability to provide appropriate, personalised support in relation to ill-health - as discussed in section 5.4.4 below - suggesting that the hypothesised link between

autonomous flexibility and appropriate personalised input to claimants has not always operated in practice.

Assessor

The studies indicated that many Personal Advisers were likely to ask claimants to provide details about their health in WFIs (Barnes et al. 2010), but the timing and approach of these discussions varied and did not always take place during a first meeting (Knight et al. 2005, Hudson et al. 2010). Therefore, this assessor role dimension involved the identification of claimants' health circumstances and any health-related barriers to employment. One study showed that individual Personal Advisers had different views about the level of health-related information they felt is necessary to illicit from a claimant (Dixon, Mitchell and Dickens 2007). Hence, the Personal Adviser may have gathered health-related information, for example, medical assessments that were carried out as part of the benefits claims process, in this role. This task may not be straightforward because medical assessments have not always been received in a timely manner (Knight et al. 2005). Additionally, Personal Advisers have been shown to have mixed views about the usefulness of such assessments (Knight et al. 2005, Barnes et al. 2010) as they may not have provided usable information to guide their work (Macmillan Cancer Support 2010).

When trying to gain an adequate understanding of a claimant's health condition, through questioning, some Personal Advisers felt concerned that they might be perceived to be inappropriately prying into a claimant's personal life (Dixon, Mitchell and Dickens. 2007, Hudson et al. 2009). Other Personal Advisers struggled to know the extent of health information that they should be aware of, and had concerns about not being '*health specialists*,' perceiving that other people, such as healthcare professionals, should provide this information (Hudson et al. 2009, p55).

'I could jump in and say something completely wrong and send them off on the wrong track completely.' (Jobcentre Plus IBPA [Personal Adviser])

(Hudson et al. 2009, p55).

Claimants' accounts in several studies also revealed varied views about the level of health information they believed a Personal Adviser should have about

their health condition (Dixon, Mitchell and Dickens 2007, Patel, Greasley and Watson 2007, Hudson et al. 2009). This appears to have influenced the way in which some claimants choose to disclose their health 'story' or whether they withheld information from their Personal Adviser (Dixon, Mitchell and Dickens 2007, Hudson et al. 2009, Macmillan Cancer Support 2010, Grant 2010). By withholding information, a claimant may hinder a Personal Adviser's practice. While some claimants appeared to accept that Personal Advisers may not fully understand their health condition (Hudson et al. 2009), other evidence indicated that potential mismatches of expectations could create frustrations and uncomfortable atmospheres in WFIs (Heenan 2003, Dixon, Mitchell and Dickens 2007). From the evidence reviewed, it was difficult to determine whether Personal Advisers commonly informed claimants of their own level of understanding about health conditions, openly acknowledged any limitations or stated their role boundaries.

Once health information has been obtained, evidence indicated that Personal Advisers may have engaged in diagnostic type activities, analysed and interpreted medical information. From both Personal Advisers' and claimants' perspectives, this could be challenging, particularly in relation to identifying suitable types of work as already highlighted (Patel, Greasley and Watson 2007, Townsend 2008, Macmillan Cancer Support 2010, Grant 2010, Barnes et al. 2010).

Counsellor

Many studies showed that Personal Advisers may have adopted counselling type activities or techniques such as: listening; showing empathy; and providing reassurance (Hennan 2002, Hennan 2003, Knight et al. 2005, Dixon, Mitchell and Dickens 2007, McNeil 2009, Hudson et al. 2009, Macmillan Cancer Support 2010, Hudson et al. 2010). Traditional style counselling activities can support building rapport and trust (Thompson 2003). Claimants' views illustrated the value and the importance they attributed to this role dimension, especially when a Personal Adviser was able to show empathy and understanding of the impact of a claimant's health condition (Dixon, Mitchell and Dickens 2007, Macmillan Cancer Support 2010). However, some Personal Advisers' accounts revealed that they felt uncomfortable with these elements and perceived counselling activities to stretch beyond the boundaries of their role (Macmillan Cancer

Support 2010). Thus, engagement in these activities could be emotionally demanding (Knight et al. 2005, Green and Shuttleworth 2010).

Gatekeeper

Personal Advisers needed to make decisions about which interventions they discussed and offered to claimants. Within the PtW programme, Personal Advisers were able to access a range of provision called Choices which included a CMP. However, given that only a limited number of the PtW participants engaged in CMP (DWP 2011c, DWP 2011d), some claimants may have benefited from more understanding about how this programme could help address their health-related barriers (Hudson et al. 2009, Macmillan Cancer Support 2010) which in turn may have then encouraged more programme participation. Gaps in health-related support provision were found in the PtW programme (Knight et al. 2005, Nice, Irvine and Sainsbury 2009, Barnes et al. 2010, Hudson et al. 2010). But, the evidence reviewed does not indicate what else may have been offered by a Personal Adviser when claimants declined a health-related provision, or it was not available, and whether these individuals then become 'parked' in the system without support. However, one study revealed that claimants with severe mental health conditions were more likely to be 'parked' than those with other conditions in PtW programmes which were delivered by provider organisations involving the private and not for profit sector (Hudson et al. 2010).

The review found that some Personal Advisers had considerable autonomy in their decision making practice and using their own judgement when working with claimants (Green and Shuttleworth 2010). Six of the studies reviewed, found that Personal Advisers referred to "types" of claimants that were perceived as difficult to work with (Joyce and Pettigrew 2002, Knight et al. 2005, Fletcher 2008, Hudson et al. 2009, Green and Shuttleworth 2010, Hudson et al. 2010). These types included: people with drug and alcohol addictions or mental health conditions; claimants with mandatory status; males in their 50s with physical health conditions who had been out of work for a long time, and groups of claimants who lived in specific geographical areas. These perceptions - and the labelling of claimants that they imply - may be important because there is some suggestion that Personal Advisers' attitudes or beliefs may have influenced the level of support they provided to claimants (Wright 2003) and the

way in which they delivered services (Green and Shuttleworth 2010). However, some Personal Advisers demonstrated that they continued to support those who have been perceived as 'harder to help' to progress (Knight et al. 2005). But perhaps, nevertheless act as gatekeepers selecting claimants whom they believed to be appropriate to offer support to.

Personal Advisers adopted a range of approaches to 'selling' provision. It is difficult to understand fully what might have influenced Personal Advisers' decisions, although they may have had concerns about overwhelming claimants (Dixon, Mitchell and Dickens (2007), and therefore, limited the information provided (McNeil 2009). Personal Advisers may have also restricted what they offered if they perceived a claimant's health condition would prevent them from working (Hudson et al. 2010). Moreover, some Personal Advisers described how they could be encouraged, by their organisation, to use specific services (Green and Shuttleworth 2010), and some had referral targets related to certain provision (Knight et al. 2005). In other circumstances, Personal Advisers had procedural guidance to support their decisions, but this appeared patchy across different organisational contexts that offered the same programme (Nice and Davidson 2010) and highlights disparities. A further indication of the level of discretion Personal Advisers have exercised can be seen when they choose to ignore procedural guidance (Nice and Davidson 2010) or managers' directives (Nice, Irvine and Sainsbury 2009). This raises potential concerns about equity, and whether some individuals were intentionally included or excluded from accessing provision. The review offered limited insights into formal methods of monitoring Personal Advisers to ensure that claimants' health needs were consistently identified and addressed equitably. In one study, one-to-one case reviews with a line manager to explore Personal Advisers' performance were found to be common in provider organisations, across four districts (Hudson et al. 2010). Some of these organisations also utilised peer case reviews (Hudson et al. 2010).

Navigator

A navigator role was made explicit in McNeil's (2009) study. Six of the studies illustrated how Personal Advisers may have needed to offer holistic support to people who may have multiple barriers to employment, for example, financial worries (McNeil 2009, Hudson et al. 2009, Nice, Irvine and Sainsbury 2009,

Green and Shuttleworth 2010, Barnes et al. 2010, Pittam, Secker, and Ford 2010). These barriers may have impacted on claimants' overall mental health. Here, Personal Advisers needed to have a good understanding and knowledge of the services that were available beyond their immediate organisational programme, to be able to signpost individuals (McNeil 2009, Green and Shuttleworth 2010). It is likely that factors relating to this role will link to the gatekeeper role, and may have been influenced by whether the claimant expected and sought such support from a Personal Adviser.

Seller

A 'salesperson' role was made explicit in some of the studies reviewed in relation to selling provision to claimants for example, McNeil (2009). Seven of the studies also implicitly indicated a "seller" role dimension (Knight et al. 2005, Patel, Greasley and Watson 2007, McNeil 2009, Barnes et al. 2010, Hudson et al. 2010, Green and Shuttleworth 2010, Grant 2010) in which the Personal Adviser's role may have involved being a 'job broker' to sell job opportunities and vacancies to claimants and to 'sell' claimants to potential employers (McNeil 2009, Barnes et al. 2010). However, there appeared to be variation across these studies in the extent of engagement Personal Advisers had with employers, and whether they perceived this to be part of their role (Knight et al. 2005, Hudson et al. 2010, Barnes et al. 2010). Some organisations also used separate job broker services (Hudson et al. 2009). One study showed it was common for Personal Advisers to have minimal contact with employers and that their employing organisation did little to promote improving this (Knight et al. 2005). In contrast, another study showed that organisations facilitated Personal Advisers' involvement with employers, for example, by arranging in-house joint meetings (Barnes et al. 2010). Similarly, some Personal Advisers had little experience of liaising with employers, who might be receptive to recruiting individuals with health conditions, because specialist Personal Advisers, for example, Disability Employment Advisers had typically adopted this role (Knight et al. 2005). Additionally, in two studies Personal Advisers' views about whether certain employers would hire someone with a certain health condition varied (Knight et al. 2005, Green and Shuttleworth 2010). In some circumstances, Personal Advisers appeared to be knowledgeable about local employers who were known to be more positive about recruiting individuals with

health conditions and this may have made this task easier, again illustrating their gatekeeper role (Green and Shuttleworth 2010).

Advocate

Evidence in six of the studies reviewed suggested that Personal Advisers may have adopted an advocate type role (Joyce and Pettigrew 2002, Dixon, Mitchell and Dickens 2007, Nice, Irvine and Sainsbury 2009, Hudson et al. 2010, Barnes et al. 2010). For example, if they disagreed with a claimant's medical assessment (Joyce and Pettigrew 2002, Hudson et al. 2010, Barnes et al. 2010). This role dimension potentially conflicts with the underpinning theory which assumes that a Personal Adviser will support claimants to make progress towards work. As, instead of embarking on the back-to-work journey, some Personal Advisers opted to support claimants to appeal against their medical assessment decision and may have also perceived they were too ill to work (Barnes et al. 2010). Arguably, this was not surprising given the high number of appeals that claimants have made following the decision outcome of their medical assessment (which determines their eligibility for benefit entitlement and capability for work). Additionally, an external review of this medical assessment identified weaknesses (Tarr 2010) and recommended key areas for improvement (Harrington 2010). There was some evidence that Personal Advisers struggled to employ their enabler role as many claimants who undertook an appeal were also reluctant to engage in work related activities in case these jeopardised their appeal process (Barnes et al. 2010). Nevertheless, by adopting an advocate role a Personal Adviser may also support the legitimisation of a 'sick role' and facilitate claimants' exemption from obligations to engage in work related activities. This links to the assessor role and shows how the Personal Adviser may have "diagnosed" a claimant as "too sick to work". It also emphasises Personal Advisers' ability to engage in discretionary decision making and how their perceptions of illness might have influenced their practice. The evidence shows strong evidence that Personal Advisers were likely to enact a variety of roles in their day to day practice when working with claimants who had health-related needs.

5.4.4 Proposition 4: Personal Advisers will be equipped and supported to address claimant's health-related barriers

The programme theory includes important assumptions about how Personal Advisers will be equipped and supported to address health-related barriers.

The review identified strong evidence that in practice a range of factors relating to their individual skills and confidence, internal organisational context and external factors could undermine their ability to provide adequate support and thereby undermine claimant progress towards work.

Skills and confidence

Personal Advisers' abilities to address claimants' health-related issues and their level of health-related expertise were shown to vary. One study found that some Personal Advisers felt confident to explore certain health issues with claimants, but could struggle with mental health and more complex conditions (Barnes et al. 2010). Therefore, some Personal Advisers were not necessarily aware of the extent or impact of a claimant's health condition.

“Actually felt a bit sorry for her [IBPA] as she wasn't aware of my medical situation, I had to explain to her I've been diagnosed with cancer...”

(Macmillan Cancer Support 2010, p19).

Not being aware may be especially pertinent when the Work Capability Assessment (WCA) provided limited information about claimants' health circumstances in relation to working (Macmillan Cancer Support 2010). Hence, Personal Advisers may employ strategies to support their practice and increase their competence. For example, reviewed studies documented Personal Advisers' use of the internet or medical dictionaries to gain a better understanding about general health information (Dixon, Mitchell and Dickens. 2007, Hudson et al. 2009); drawing on their personal experience (Fletcher 2008); or liaising with healthcare professionals to find out about a claimant. Advice that was given by other professionals has shown to benefit Personal Advisers' practice. This included advice from their peers, Work Psychologists, line managers (Knight et al. 2005, Nice, Irvine and Sainsbury 2009) and healthcare professionals, particularly in the PtW CMP (Nice and Davidson 2010) as shown in Chapter Three. This advice supported some Personal Advisers' decision making practice (Hudson et al. 2010), for example, by learning how to improve their interactions with claimants and increase their knowledge about individuals' health conditions (Nice and Davidson 2010). Conversely, one study found that some Personal Advisers felt healthcare professionals gave conflicting advice about a claimant's work capability which could then made their interactions with a claimant difficult (Hudson et al. 2009).

However, the evidence suggests there have been variations in whether Personal Advisers have had the opportunities to liaise and develop relationships with professionals in health services (Macmillan Cancer Support 2010), or local services in general (Fetcher 2008).

The review indicated variations in the level of training which was made available for Personal Advisers by different organisations (McNeil 2009) and some inconsistencies were highlighted (Fletcher 2008). Personal Advisers' views about the effectiveness of their organisations' training were found to be mixed (Knight et al. 2005) and some felt that the training they received was inadequate, in relation to learning about claimants' health conditions, particularly mental health (McNeil 2009, Hudson et al. 2010). Therefore, having more health-related training was viewed positively by many Personal Advisers in many of the studies reviewed (Joyce and Pettigrew 2002, Knight et al. 2005, Townsend 2008, McNeil 2009, Hudson et al. 2009, Hudson et al. 2010).

Internal organisational structural factors

Although organisations have adopted different approaches in how they decided to support Personal Advisers' practice (McNeil 2009), there were some similarities across studies in the reporting of how advisers experienced tensions in their role. Factors that were shown to hinder or constrain Personal Advisers' practice included: having limited time to spend with claimants; managing large caseloads; line managers' directives; and performance management issues. These factors will be described in turn.

Time constraints were indicated to limit Personal Advisers' opportunities to build rapport with claimants, and thus, establish an effective relationship (Hudson et al. 2010). Sufficient time was necessary to help enable Personal Advisers to find out more about claimants' needs and barriers (Dixon, Mitchell and Dickens 2007, Fletcher 2008, McNeil 2009) and engage in an assessor role. Insufficient time also reduced the likelihood of being able to personalise sessions and engage in a case management role in some cases (Hudson et al. 2009). Personal Advisers' time could be restricted in circumstances where there were staff shortages, for example, for sick leave (Dixon, Mitchell and Dickens 2007) or where tasks such as administration could be time consuming (Joyce and Pettigrew 2002, Knight et al. 2005), or when they had large caseloads (Fletcher 2008).

Two studies illustrated that Personal Advisers can have mixed views in terms of whether having a large case load hindered their work with claimants. For example, some Personal Advisers did not experience any pressures (Knight et al. 2005) while others felt that increased workloads could affect their morale and effectiveness (Joyce and Pettigrew 2002, Knight et al. 2005). For example, increased work load demands could lead to '*compassion fatigue*' which some Personal Advisers felt could prevent them from being able to give their full attention to claimants' needs (Knight et al. 2005, p43). As workload demands were also shown to influence Personal Advisers' ability to empathise (Knight et al. 2005) they may have been less effective in adopting the counsellor role dimension and collaborative relationship which were described earlier. This could potentially have affected the nature and quality of their relationship with a claimant and any progress an individual made towards working.

In some studies, directives from line managers were found that aimed to influence Personal Advisers' practice. These directives might have undermined Personal Advisers' autonomy, discretion and flexibility to tailor support. For example, one study revealed that Personal Advisers were told by their manager that they were focusing too much on claimants' health conditions and neglecting other relevant issues such as confidence (Hudson et al. 2010). Some provider organisations also used claimant classification systems to help prioritise Personal Advisers' workloads by identifying which claimants were perceived to be work ready (Hudson et al. 2010). These systems were not unique to one programme or organisation (Joyce and Pettigrew 2002, Hudson et al. 2010). However, in one study some Personal Advisers demonstrated the autonomous nature of their role by overriding classification systems and continued to support claimants who are perceived to be 'harder to help' (Hudson et al. 2010). In addition, directives from managers to limit use of certain provision were indicated in relation to cost factors, but some Personal Advisers did not let this influence their decisions (Nice, Irvine and Sainsbury 2009).

Performance management issues appeared salient in situations where Personal Advisers' practice could be influenced by the need to achieve targets (Fletcher 2008). Being required to meet targets may have encouraged Personal Advisers to work selectively with claimants who are perceived to be closer to gaining employment (McNeil 2009). This could lead to 'creaming and parking' practice

(Hudson et al. 2010) which resulted in claimants receiving differential levels of support as shown in the two quotes below from Personal Advisers.

'...there has been a massive shift from actually working with our client group, working with a caseload of clients and moving everyone closer to almost creaming the top off and working with them and processing the less ready clients, I would say.' (Provider Adviser)

(Hudson et al. 2010, p56).

Only one of the studies reviewed indicated that Personal Advisers' individual targets may encourage a competitive culture amongst teams and limit collaborative working (Joyce and Pettigrew 2002). There was some evidence to suggest that Personal Advisers were not motivated by any associated financial incentives i.e. annual bonus (Joyce and Pettigrew 2002, Grant 2010). Some of the evidence also suggested that targets may not necessarily be negatively experienced by all Personal Advisers, because there were variations in how they dealt with this issue (Knight et al. 2005, Green and Shuttleworth 2010, Grant 2010, Hudson et al. 2010). For example, at one end of the continuum Personal Advisers could be target focused, (Hudson et al. 2010) and/or be worried about these (Grant 2010), in contrast to those who continued to provide full support, despite having targets, because it was perceived to be in the best interests of claimants (Knight et al. 2005, Grant 2010, Hudson et al. 2010). But regardless of the stance taken by individual Personal Advisers, having to achieve targets could create role tensions (Knight et al. 2005, Hudson et al. 2010). These tensions could lead to low morale (Joyce and Pettigrew 2002, Hudson et al. 2010) and stressful experiences (McNeil 2009), especially if they were perceived to be unachievable within the confines of caseload numbers (Joyce and Pettigrew 2002) or 'unrealistic' (Hudson et al. 2010, p53).

Potentially these tensions could lead to work related stress which could subsequently impact on Personal Advisers' health and work performance (Health and Safety Executive 2007). For example, dealing with claimants' health issues could cause worry, and in one study Personal Advisers felt they lacked the competence to respond (Green and Shuttleworth 2010). It is not known whether these impacts could be a contributory factor to the high staff turnover within the welfare-to-work industry which was highlighted (Joyce and Pettigrew 2002, Fletcher 2008, Nice, Irvine and Sainsbury 2009, McNeil 2009,

Green and Shuttleworth 2010, Hudson et al. 2010), as low pay has also been shown to be a risk factor (McNeil 2009, Hudson et al. 2010). Conversely, staff turnover was not always felt to be negative, as some staff felt that new Personal Advisers could be more motivated (Fletcher 2008). This raises pertinent questions about Personal Advisers experiencing 'burn out', and whether they were adequately supported to manage the emotional challenges of their role, which were highlighted in the counsellor role dimension, already discussed. Any impact of 'burn out' could presumably have implications in a Personal Adviser's ability to build a collaborative relationship with a claimant, particularly if this resulted in a lack of adviser continuity through sickness absence or presenteeism (being in work while unwell (Health and Safety Executive 2013)), which would limit their ability to work productively.

External organisational factors

The evidence reviewed indicated that the Personal Advisers' role in relation to meeting needs of people with illness was dependent on some external organisational factors. These included: having medical information, health-related provision and healthcare professional input.

As already shown, medical information, for example, the WCA was not always perceived to be helpful to supporting Personal Advisers' practice. Hence, it is unsurprising that one study found that more involvement and information about claimants' health, with input from GP's, was desired by some Personal Advisers (Hudson et al. 2009). However, two additional studies (which related to the same time period and PtW programme) showed that some Personal Advisers had limited involvement with external healthcare professionals (Macmillan Cancer Support 2009, Nice, Irvine and Sainsbury 2009) and that partnerships between employment support organisations and the NHS were underdeveloped (Macmillan Cancer Support 2010).

Some Personal Advisers valued being able to signpost claimants to appropriate external provision, and these services were considered to be necessary to support claimants to progress towards working (Knight et al. 2005). Having a good understanding about local services and provision was important, because this has enabled Personal Advisers to assess if they are suitable (Nice, Irvine and Sainsbury 2009). However, having time to be better informed about such services was not always possible (Knight et al. 2005, Nice, Irvine and Sainsbury

2009). This suggests that some managers may not have recognised the value of setting aside protected time for this task which Green and Shuttleworth (2010) point out, may be required in some areas more than others for example, if staff are replaced and local knowledge is lost. The review identified strong evidence that in circumstances where Personal Advisers had limited knowledge of local provision this affected their ability to perform a gatekeeper and navigator role.

5.5 Stage four: discussion and drawing conclusions

This section discusses the findings in relation to the four propositions that were tested, and explores two key concerns about Personal Advisers' practice, the legitimacy of their role, and their competence. It also considers implications for practice and policy and raises questions about how Personal Advisers could be better supported to work with claimants who have health conditions. It begins by highlighting the strengths and weakness of the theory driven approach adopted for this review.

This review sought to synthesise evidence on Personal Advisers' experiences and approaches to supporting individuals with long-term illness to move into work. It aimed to test and expand four propositions:

- I. A collaborative relationship between the Personal Adviser and the claimant will be developed and will support progress towards getting into work.
- II. A balance between "enforcer" and "enabler" will be possible and will support progress to work.
- III. Flexibility and autonomy to respond to individual claimants will enable Personal Advisers to adapt and develop a personalised input.
- IV. Personal Advisers will be equipped and supported to fulfil their role in addressing claimants' health-related barriers to work.

Drawing on a realist approach has been useful to gain an understanding of the ways in which Personal Advisers have worked within the welfare-to-work context prior to the current Work Programme period and the potential influence of their behaviour and skills upon their practice, rather than simply asking "do Personal Adviser's interventions work?" The organisational context and

management structures have also been shown to constrain or support their practice. One advantage of adopting a realist approach has been the synthesis of a variety of evidence sources which included studies of employment support programmes (many involving the PtW programme) which ran over a number of years, were conducted in different geographical locations in a range of organisations and had participation from a wide range of claimants. Although, a small number of papers were reviewed, most of these included in-depth qualitative data which provided rich information about the experiences of both Personal Advisers and claimants. Thus, this evidence has provided insights into the potential casual pathways and relationships rather than quantitative outcome measures.

In terms of limitations in searching for evidence, there were difficulties in retrieving relevant papers from the electronic databases, because there is inconsistent use of terms and indexing of return to work studies (Bambra et al. 2005, Gehanno et al. 2009). Therefore, it is assumed that some studies were not retrieved. Some of the studies may not have been representative of the wider population and may have a bias towards JCP Personal Advisers. In addition, the nature of this type of review demands a degree of researcher interpretation which can result in potential bias (Wong et al. 2010).

A Personal Adviser is required to adopt different roles in order to provide health-related interventions to claimants.

The role of a Personal Adviser has been shown to be multidimensional. Hence, Personal Advisers often needed to wear numerous "hats" when supporting claimants with health conditions to secure paid work. This review has highlighted how the Personal Adviser's role implicitly required the provision of health-related support type interventions such as counselling and diagnosing type activities. However, engagement in these interventions could be emotionally challenging, particularly if Personal Advisers had not been adequately equipped or supported. These activities are also typically associated with a healthcare professional role. However, there are many differences between the role of the Personal Adviser and a healthcare professional. A healthcare professional is required to pass an accredited course of training, follow their professional body's code of conduct, standards of practice, is held professionally accountable for their practice and receives

supervision (e.g. Health and Care Professions Council 2010). In contrast, the Personal Adviser role has only begun in recent years to achieve some of these requirements, with the ongoing work to professionalise this role, as shown in Chapter Three. These issues will be further explored in Chapters Eight and Nine. In addition, there appears to be a need for organisations to consider, and provide further training for Personal Advisers in claimants' health-related barriers and the effects of conditions, especially mental health.

A collaborative relationship between the Personal Adviser and the claimant is needed if progress towards getting into work is to be achieved.

Developing a collaborative relationship with a claimant has been shown to be of benefit and something that many Personal Advisers were keen to strive to achieve. If achieved, this may not only support claimants' health, but encourage their 'buy in' to programmes and to take up the support options offered, such as a CMP. Factors that could hinder this relationship were identified. Some of these were related to the organisational context and culture and therefore beyond the control of the Personal Adviser. However, some related to Personal Advisers' individual practice, because some claimants were unclear about the Personal Adviser's role, and how she/he could support their health. Additionally, claimants had varied expectations of their Personal Adviser in relation to health issues. Therefore, claimants may benefit from having an explicit understanding about the role of a Personal Adviser in relation to health because this might reduce any misunderstandings that were shown to be evident in some circumstances. Giving clear role explanations may also support the legitimacy of why claimants' health information may be of benefit to the Personal Adviser. In turn, this might reduce some of the Personal Advisers' concerns about prying into claimants' personal lives that were identified in the review. Equally, if a Personal Adviser is not explicit about what they can offer, or ignores health issues, a claimant's understanding and decisions regarding what action to take in terms of sharing information may be affected.

A claimant can experience setbacks in their back to work journey if a Personal Adviser is not equipped and supported to fulfil their role and able to consider their health-related barriers.

The level of knowledge and understanding Personal Advisers had about health conditions appeared linked to how they addressed claimants' health-related

issues in their practice. Understanding the impact of a claimants' health condition and identifying suitable forms of work may be a challenging task, and there are examples where trained healthcare professionals have struggled to achieve this (Cohen et al. 2010). Although Personal Advisers have not been expected to be healthcare 'experts' (as shown in Chapter Three), there appeared to be an implicit assumption in the programme theory that they should have been able to provide interventions for people with long-term illness.

Personal Advisers have been shown to have varied perceptions about claimants' health conditions and their employability, which can influence their judgement and decision making practice. In some cases, these judgements appear to have differed from the information presented in claimants' medical assessments. This draws our attention to the potential risks of claimants being medicalised by Personal Advisers. They may indicate or suggest individuals need some form of medical intervention which may not be required. This may hinder a claimant's progress given a positive work message is advocated (Patel, Greasley and Watson 2007). On the other hand Personal Advisers' inadequate understanding of a health condition or views about what they think they should be aware of may also exacerbate an individual's illness or push them further away from employment.

Constraints imposed by Personal Advisers' organisational structures could undermine their ability to perform dimensions of their role, and this may hinder or prevent meeting claimants' needs. For example, directives from line managers influenced some Personal Advisers' practice (Hudson et al. 2010) and the pressure of having to achieve targets may have encouraged Personal Advisers to offer more support to those perceived as being closer to getting back into work (McNeil 2009). Clearly support from healthcare professionals can be valuable, not only in terms of providing specific health-related interventions, but in facilitating the Personal Advisers' practice by improving their general health knowledge as shown in Chapters Three and Seven. However, establishing such partnerships may not be possible without organisational support, and therefore, limit integration between health-related services that has been shown to be beneficial and important to help claimants address their health-related barriers and progress into work in Chapter Three.

Cross cutting themes

Two cross cutting themes: the competency and legitimacy of the Personal Adviser's role in relation to health-related support emerged in the review findings.

Competence

The extent of health-related knowledge, skills and expertise individual Personal Advisers had when working with claimants' health conditions was found to vary, both within, and across, organisations. These variations have been linked to Personal Advisers' employing organisation's investment decisions regarding equipping and supporting their practice, particularly, in whether they provided training. In the absence of being required to work to a standardised competency framework, Personal Advisers' different levels of competency, combined with their autonomy and discretion, pose a number of risks relating to ensuring claimants receive equitable and effective interventions. Therefore, given that there was limited evidence in the studies reviewed to understand if Personal Advisers working in the pre-Work Programme period were monitored to ensure that health-related barriers were assessed and addressed for all claimants, some people may have been left unsupported, especially where they may have been reliant on advisers adopting a gatekeeper role.

Legitimacy

The findings reveal that there are likely to be different stakeholder perspectives about the legitimacy of the Personal Adviser's role in relation to supporting claimants with health-related issues. These views have reflected both individual and organisational values, and highlight the absence of a clear Personal Adviser role definition, and boundaries of support. If the legitimacy of why Personal Advisers seek to understand claimants' health-related barriers is made explicit, claimants' understandings may be improved. It may also emphasise the benefits that sharing their health story may bring. Therefore, the identification of claimants' perceptions about the legitimacy of the Personal Advisers role in supporting their health, and whether they might block a Personal Adviser from providing successful health-related support interventions is needed. This will be explored in Chapter Seven which explores the micro-level interactions between Personal Advisers and claimants. Similarly, identifying how Personal Advisers perceive their role in relation to a healthcare professional is also needed.

5.6 Conclusion

This chapter has shown that, in the period from 1998 up to 2010, Personal Advisers practiced in a range of contexts to deliver the same or different programmes. To achieve programme outcomes and support claimants with health-related needs into work, Personal Advisers have been found to choose or be required to enact certain roles. Personal Advisers' employment of these roles could be challenging and the mechanisms employed within some of their interventions could be more akin to those of a healthcare professional. Establishing a collaborative relationship has been shown to be an influential factor to facilitate positive claimant experiences, programme participation and change. However, in order to be prepared, Personal Advisers need to be equipped with the right skills, confidence and structural support that have been highlighted in this review. The positive aspects of their autonomy and discretion could be improved with consistent standards of practice and protocols, which are starting to be developed as shown in Chapter Three. This work may help define the Personal Advisers' role and boundary of support.

This review has shown that policy implementation can be experienced differently by individual claimants who access the same programme, revealing that there are potential risks of provider organisations and Personal Advisers ignoring or providing inadequate provision. This raises a number of questions about whether welfare reform policy sufficiently reflects the importance of addressing claimants' health conditions and whether it strives to ensure equity.

This review established particular issues that deserve investigation in the new structures. It has also raised other concerns and questions that were not so far adequately answered by existing evidence or Personal Adviser interventions to date. These factors will both be carried forward to the investigation of the newly emerging Work Programme. The next chapter explores the Personal Advisers' role in supporting claimants with health conditions within the new Work Programme. It also examines how claimants' health-related needs are likely to be supported by Primes. The review findings suggest that there is value in these organisations recognising and committing resources to facilitate the effectiveness of Personal Advisers' practice. In particular, this would include ensuring that Personal Advisers have: an adequate level of health-related knowledge; are given time to find out about local health-related provision and

are able to develop relationships and networks with professionals in health services; are given sufficient time for establishing claimant relationships with manageable caseloads; and have adequate support structures and protocols in place. These aspects will be considered in Chapter Six, and many of these factors will also be explored in Chapter Seven.

Chapter Six: An integrated review of the Work Programme policy and practice landscape: identifying the different menus of health-related support provision

6.1 Introduction

This chapter concerns the Work Programme policy. Its purpose is twofold. Firstly, to describe and explore the national level policy statements related to the Work Programme policy, in order to examine whether and how health-related support is incorporated, the underlying assumptions, and to identify potential risks of implementation. It also considers the problems with previous employment support provision (e.g. Pathways to Work (PtW)), which were identified in the introduction and Chapter Five for example, 'creaming and parking' practice, to ascertain whether these issues might be addressed. Secondly, it examines how the Work Programme policy objectives have been interpreted by Primes via an exploration of whether and how health-related support was proposed in their bids. To supplement this documentary analysis, I draw on new empirical data from my ethnographic participant observations and research interviews to explore how provider organisations have responded in practice. Unlike the previous PtW policy, the current Work Programme policy does not prescribe a Personal Adviser role or health-related support provision, leaving this component of each particular 'offer' to claimants to the discretion of individual provider organisations.

The chapter addresses the following research questions:

Macro-level

1. To what extent are claimants' health-related needs considered within the Work Programme policy?

2. How is health-related support incorporated within the Work Programme provider organisations' offer?

Meso-level

3. What types of health-related support are made available for claimants within the Work Programme?

4. What factors might influence the Work Programme provider organisations' provision of health-related support?

5. How do providers' organisational culture, structure and processes support/hamper Personal Advisers' practice in relation to addressing individuals' health-related needs?

Micro-level

7. What types and variations of health-related support do claimants access from their Personal Adviser?

This chapter therefore concerns the macro policy environment, meso organisational and micro individual level factors, by integrating and synthesising findings generated from a Work Programme policy analysis with my ethnographic work that was undertaken in the Work Programme and wider welfare-to-work arena. Research question 5 is addressed further in Chapter Seven. The chapter is divided into two sections. Section one provides an overview of the Work Programme contract and examines the underlying policy assumptions and associated risks that relate to supporting claimants' health-related needs. Section two analyses and synthesises the integrated findings from a documentary review and new empirical work. The chapter concludes by considering the risk factors that might undermine the success of the Work Programme, and raises questions about support provision in this new programme.

6.2 Methods

This section describes how the Canadian National Collaborating Centre for Healthy Public Policy (NCCHHP)'s four stage method for synthesising knowledge about public policies, which was described briefly in Chapter Four,

guided this policy analysis (Morestin et al. 2010). Given that the primary aim of this thesis and this review element is to explore how health-related support is considered and addressed in both policy and practice, it was pertinent to ensure the literature was interrogated to identify these aspects in detail. The six selected factors (effectiveness, unintended effects, equity, and implementation factors: cost, feasibility and acceptability) were considered when critically reviewing the literature, but it was beyond the scope of the review to explore cost factors in any great detail. In addition, two cross cutting themes, which were discussed in Chapter Three that appear to underpin welfare reforms: personalisation and conditionality were also considered. Abbott, Shaw and Elston (2004) suggest that the inclusion of such underlying ideologies can facilitate a more interpretative analysis.

I modified Morestin et al.'s (2010) stages, with stages one and three being undertaken prior to stage two, in which the logic model is identified. This modification provided more knowledge about the Work Programme which supported the subsequent development of the logic model. Integration of the new empirical data from participant observations of the welfare-to-work arena and observation of the practice arena and semi-structured interviews were considered to contribute understanding about what was happening in practice. Chapter Four provides details about how this data were generated, analysed and interpreted.

6.2.1 Stage one: Compiling a policy inventory

Relevant Work Programme policy documents were selected by conducting a search of the Department for Work and Pensions (DWP)'s website. The key documents included are shown in Box 6.1 and were also used for stage two and three.

Box 6.1 Key Work Programme policy documents used for stage one and two

Department for Work and Pensions' publications:

- The Work Programme Prospectus-November 2010 (DWP 2010c).
- The Work Programme Invitation to Tender Specification and Supporting Information- (DWP 2010e).
- Employment Related Support Services Framework Agreement Mini competitions for the provision of the Work Programme Instructions for Bidders (DWP 2010f).
- The Work Programme- August 2011 (DWP 2011a).

6.2.2 Stage two: Searching for the evidence

The second stage involved identifying relevant literature that could be reviewed to understand the Work Programme delivery and any health-related support provision. At the start of this analysis in March 2012, the Work Programme was still in its infancy. Therefore, there was limited empirical data regarding the Work Programmes' implementation and effectiveness. In addition, the Work Programme model had not been piloted so there was no prior evidence to examine or review. The literature previously retrieved for Chapters Three and Five was therefore re-reviewed and papers were selected which were considered to offer a useful contribution to the synthesis. This included literature that related to UK welfare-to-work provision and health-related support with a focus on the PtW programme and Condition Management Programme (CMP). This literature was considered useful in making comparisons between past and current policy initiatives that aimed to address claimants' health-related needs. It also raised key issues that warrant consideration in relation to the new programme environment.

In addition, a sample of 18 Primes' bid documents titled: *'Employment related support services framework agreement mini competitions for the provision of the Work Programme'* which covered 16 of the 18 Contract Package Areas (CPA) across the UK, were selected. These documents were used as a key source of insight into how national policy was translated into organisational policy and operational plans. These documents outlined Primes' delivery models, customer journeys and minimum service levels (MSL). Primes and some of their subcontractor organisations' websites were also searched to

identify any supporting information that could give further insight into the delivery. Other documents, which supplemented the analysis, were identified from further literature searches dating from 2010 to 2012. The key documents that have been included are listed in Box 6.2 and Table 6.1.

Box 6.2 Key Work Programme related documents that were reviewed for stage two

- Pathways to what? Making the single Work Programme work for people on health-related benefits (Tarr 2010).
- Opening up work for all The role of assessment in the Work Programme (Coleman and Parry 2011).
- Work Programme providers and contracting arrangements (House of Commons Work and Pensions Committee 2011b).
- Making the Work Programme work for people with health conditions follow-on report to 'pathways to what? (Tarr 2011).
- The Introduction of the Work Programme (National Audit Office (NAO) 2012).

Official Department for Work and Pensions documents:

- Minimum Service Delivery (DWP 2011b).

Morestin et al. (2010) recommend that data extraction sheets are used. These covered the six dimensions within their framework. Additional forms were designed to extract data about health-related support interventions, personalisation and conditionality. Prior to extracting data, the retrieved documents and papers were read several times. Sections of text that concerned the identified dimensions were manually highlighted, coded, cut and pasted into the relevant sections in the extraction forms. This process produced a considerable amount of data, therefore some of the data was reclassified into sub themes as suggested by Morestin et al. (2010). This was particularly relevant when identifying health-related support and producing the summary tables relating to Work Programme provider organisations. It was necessary to reread the bid documents and extract further data as new questions emerged from the analysis. Thus, the analysis was iterative.

6.2.3 Stage three: Development of the logic model

In relation to this analysis it was important to identify the way in which the Work Programme provider organisations' delivery models were being proposed. The literature reviewed in stages one and two supported the development of the intervention logic model which is described and presented in section 6.4. This model was further developed over time and refined as more understanding and information about the Work Programme was made available. This included informal consultations with stakeholders and colleagues, particularly those who worked in health.

6.2.4 Stage four: Stakeholder validation

It was not possible to arrange formal deliberative processes because of time and budget restrictions. However, the new empirical data generated through my ethnographic participant observations and research interviews that took place during 2009-2013, was considered to offer an equally valuable contribution to the synthesis. As indicated above, opportunities to test and refine the emerging analysis arose both formally and informally when communicating with key welfare-to-work actors who were embedded within the Work Programme context. This provided new information and insights. The new empirical data from interviews was used to cross-check the logic model for any inconsistencies or inadequacies. This process further emphasised the importance of the Personal Adviser role in being able to adequately identify claimants' health-related barriers and health-related support options.

6.3 Findings

6.3.1 The Work Programme intervention logic

This section describes and explains the logic model that was identified through a review of the literature as shown in section 6.2. This model is presented in Figure 6.1. This was developed as a theoretical representation of how the Work Programme policy aims to increase the employment rate of claimants who have health conditions and related barriers to employment. This logic model shows the interventions which are required to support the desired policy effect, i.e. a reduction in claimants with health conditions. The four effectiveness factors, (highlighted in red boxes), concern the Work Programme delivery model, Personal Advisers' practice, health-related support interventions and claimants' engagement.

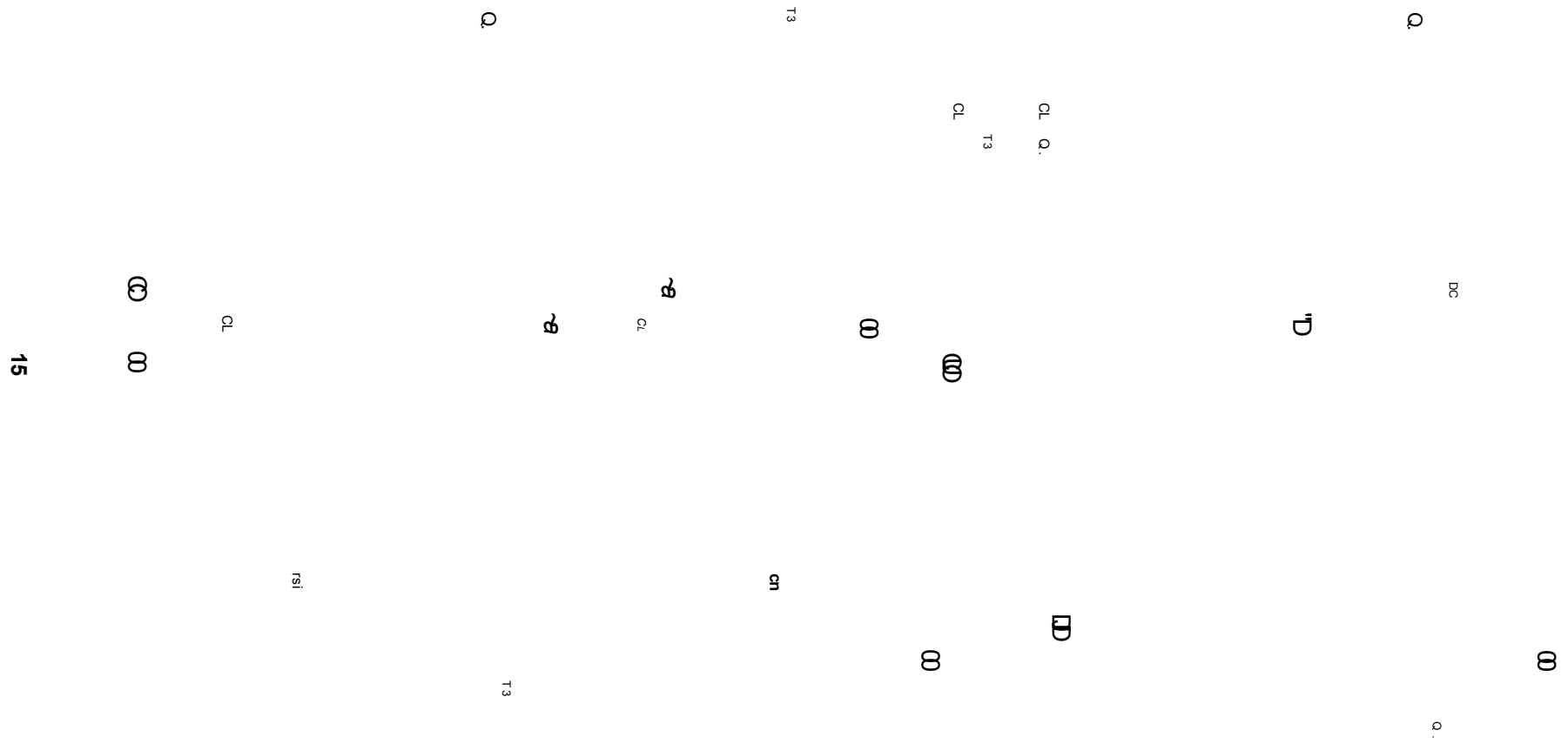
Having set out the overarching logic model, closer reading of the documentation was undertaken to unearth a number of underlying assumptions and risks which correspond to the four effectiveness factors shown in Figure 6.1. The assumptions and associated risks (with examples of supporting evidence and underlying principles of the Work Programme policy) are presented in Table 6.1. These were developed through critical reading of the literature and participant observation of the welfare-to-work arena. These assumptions and related supporting statements provide insights about how the 'claimant problem' is perceived from the Government's perspective, and how this is expected to be addressed by the Work Programme. The overarching assumption is that health is a barrier rather than wider structural issues such as a lack of jobs, but the focus here is on health-related support.

The first effectiveness factor concerns the **Work Programme delivery models**. Primes are assumed to have the expertise to determine which health-related support interventions are likely to help claimants move into and sustain work, and to be able to identify innovative and cost-effective methods of implementation. Both health and work provider organisations (i.e. local NHS and Work Programme) are assumed to have a vested interest in supporting claimants' health, and a willingness to work with each other. These delivery factors inter-relate with the second factor which assumes that **Personal Advisers' practice** can effectively support the Work Programme. Personal Advisers are perceived not only to be competent to support claimants with health conditions, but to apply conditionality measures effectively. However, provider organisations may not adequately prepare or equip Personal Advisers. The third factor concerns the **health-related support interventions**. While simple condition management interventions are assumed to support claimants who have common health conditions, innovative interventions need to be identified for claimants who have longer-term needs. There is an assumption that healthcare professionals (in-house and/or NHS) will be capable, willing and sufficiently resourced to support and provide these types of provision. The fourth factor concerns **claimants' engagement**. Conditionality is assumed to ensure claimants' engagement and adoption of appropriate work behaviours. However, there may be unforeseen risks if claimants feel pressured to comply with Personal Advisers' recommendations. This could have adverse effects on their health.

From a policy aim and interventional approach point of view, questions about whether the Work Programme is feasible, acceptable, and likely to support claimants with health conditions into sustainable work are raised. For example, the labour market can be hostile to those with poor health (Patrick 2011) and some work can make health worse (Waddell and Burton 2006). There are also questions about; whether there is a need to test some of the key assumptions; whether these will fall into place; or whether there will be any unintended consequences or risks, particularly concerning equity, that could arise as a result of the delivery approach.

The next section presents a descriptive analysis of what was documented in the Primes' bids in relation to the key questions from this part of the review. The last section of this chapter will revisit the risks identified in Table 6.1.

Figure 61 Work Programme intervention logic in relation to claimants with health-related needs



Black solid lines relate to the Work Programme policy objectives.

Table 61 Work Programme policy assumptions and risks in relation to claimants who have health conditions

<p>Work Programme Policy Assumptions</p>	<p>Policy Assumptions</p>	<p>Risks</p>
<p>Assumption 1: Claimants with health conditions will be able to engage in work activities.</p>	<p>Assumption 1: Claimants with health conditions will be able to engage in work activities.</p>	<p>Risk 1: Claimants with health conditions may not be able to engage in work activities.</p>
<p>Assumption 2: Claimants with health conditions will be able to access support services.</p>	<p>Assumption 2: Claimants with health conditions will be able to access support services.</p>	<p>Risk 2: Claimants with health conditions may not be able to access support services.</p>
<p>Assumption 3: Claimants with health conditions will be able to find suitable employment.</p>	<p>Assumption 3: Claimants with health conditions will be able to find suitable employment.</p>	<p>Risk 3: Claimants with health conditions may not be able to find suitable employment.</p>
<p>Assumption 4: Claimants with health conditions will be able to maintain their health.</p>	<p>Assumption 4: Claimants with health conditions will be able to maintain their health.</p>	<p>Risk 4: Claimants with health conditions may not be able to maintain their health.</p>
<p>Assumption 5: Claimants with health conditions will be able to participate in training and education.</p>	<p>Assumption 5: Claimants with health conditions will be able to participate in training and education.</p>	<p>Risk 5: Claimants with health conditions may not be able to participate in training and education.</p>
<p>Assumption 6: Claimants with health conditions will be able to access financial support.</p>	<p>Assumption 6: Claimants with health conditions will be able to access financial support.</p>	<p>Risk 6: Claimants with health conditions may not be able to access financial support.</p>
<p>Assumption 7: Claimants with health conditions will be able to access housing support.</p>	<p>Assumption 7: Claimants with health conditions will be able to access housing support.</p>	<p>Risk 7: Claimants with health conditions may not be able to access housing support.</p>
<p>Assumption 8: Claimants with health conditions will be able to access transport support.</p>	<p>Assumption 8: Claimants with health conditions will be able to access transport support.</p>	<p>Risk 8: Claimants with health conditions may not be able to access transport support.</p>

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6.4 Work Programme policy and provision: Supporting claimants' health-related needs

The national-level policy framework of the Work Programme was described in general terms in Chapter Three. Having now identified within this, key underlying assumptions and potential risks, I now turn to explore how this policy was understood and responded to by the Primes. This section begins with a general description of the prominence of health within the bid documents, and then explores the findings in relation to the four effectiveness factors that were identified from the Intervention Logic Model presented in Figure 6.1.

6.4.1 Prominence of health

In relation to supporting claimants' health-related needs, DWP's (201 Oe) invitation to tender specification and supporting information stated that bidders should describe their intentions to tailor support to meet the needs of any *'disabled customers or those with health conditions/* (DWP 201 Oe, p38) irrespective of the benefit they receive. DWP's (201 Of) instructions for bidders' document covers this aspect by asking provider organisations to *'...describe how [they] will ensure the customer journey is tailored to meet the specific needs and barriers of individual customers...'* (DWP 201 Of, p24). Although health conditions were not specifically defined within the DWP Work Programme specification per se, it was evident that claimants who experienced 'serious' effects from their health condition will not be expected to engage in work related activities or work (DWP 201 Oe, p37).

All of the Primes made reference to claimants' health-related needs within their bid documents, but there was varied prominence and lack of common detail. Although many different types of health-related support were documented within the bids, there was inconsistent reference to whether these had a health, a work or an integrated focus. For example, A4e¹² (2011) adopted a work focus in this statement:

'...specialist health assessment (...) that identifies capacity to work with realistic job goals and an achievable action plan. APM will also provide

¹²Page numbers were manually inserted into the provider organisations' bid documents. Quotes in single quotation marks relate to bid statements. Quotes in double quotation marks are verbatim quotes from interviews. (...) indicates that some text has been removed. Words in [] replace text to add clarification, or to maintain participants' confidentiality.

condition management to enable customers to manage their health in work'

(A4e 2011, p11).

Then a health focus in this statement:

'Mental health and [musculoskeletal] (MSK) will be the focus of our condition management and wider health support offer and we anticipate supplementing existing mental health provision (...) where [Primary Care Trust] PCT demand for mental health provision exceeds supply'

(A4e 2011, p54).

and an integrated focus in this statement:

'A robust health programme: A4e has developed a robust, integrated model to support the anticipated 26,500 JSA and ESA/IB customers with health-related barriers. Our partnership with APM, providing specialist health assessments and condition management, will allow A4e to accurately identify each customer's work capacity, suitable job options and provide appropriate support'

(A4e 2011, p15).

However, many of the Primes' provider organisations' related statements had a strong association with work outcomes (i.e. claimants moving into work). Interestingly, only one provider organisation - A4e - used a 'work-focused health-related support' (A4e 2011, p9) descriptor in their bid document.

Close scrutiny of the Primes' minimum service levels (MSL) provides a useful illustration of the prominence given to claimants' health. Each Prime was required to outline their MSLs in their bid document and provide a summarised version for claimants. Although not explicitly in relation to health, the NCVO (2011) points out that these summaries were '*... vague and ambiguous documents varying in detail from a few bullet points for one prime to over a page and a half for another*' (NCVO 2011, p6). Only five of the 18 Primes made explicit reference to addressing claimants' health-related needs prior to starting work, as shown in Table 6.2. In contrast, other Primes' summaries stated how support will be tailored, emphasising dedicated Personal Advisers. The lack of reference to addressing health within these summaries does not necessarily mean that Primes do not intend to offer health-related support. For example,

health-related support could be documented in the MSLs section within the bid document, or elsewhere to some extent.

Nevertheless, what is of concern is whether health-related support will be made available to claimants in practice. The 'selling' of the PtW CMP was generally controlled by Personal Advisers, and there is evidence of some selectivity about which claimants received this information (Hayllar and Wood 2011). Some Primes for example, BEST (2011), EOS (2011), Serco (2011), and Pertemps (2011) stated that they will share their MSLs when claimants join their programme. However, the extent to which any information relating to the availability of health-related support will be shared is unclear. My observations at practice level found that MSLs were not always explained to claimants (in relation to health), during welcome inductions. Therefore, it is uncertain how claimants will: interpret their summary, if read; act upon the information received; or make a complaint if health-related support is not offered. Further questions about how these 18 different MSLs will be monitored by DWP, particularly if health is not explicitly included in an organisations' key performance indicators (derived from their MSLs) are also raised.

Table 6.2 Explicit reference to supporting claimants' health in Primes' summarised minimum service levels (5 out of 18 organisations)

Prime	Reference to health
A4e	Health support: we will assess health as a barrier to working. Those identified as needing additional assessment/support will be referred to a specialised health assessment and support to develop a health-focused back to work plan.
CDG	Stage Four: Pre-Employment Preparation 1. Customers with health problems or caring responsibilities are to be offered Work Programme support through a community hub or alternative convenient location, including home visits where required.
G4S	Every Customer will have access to the G4S Knowledge Bank. Many Customers will require expert additional intervention to overcome barriers to finding and sustaining employment. All Customers have access to specialist Knowledge Bank services. This includes a range of support including condition management, occupational health support, childcare services, career advice, mentoring, debt advice, housing advice and vocational training.
Maximus	Phase Three - Assessment All customers undertake an assessment with a dedicated EC or Health Officer.
Serco	Refer you to one of our specialist providers if you have particular needs, such as a health condition or physical disability, or want specific employment advice, such as how to start your own business.

NOTE: 13/18 Primes made no explicit reference to addressing claimants' health prior to starting work in the minimum service levels.
(DWP 2011b, p1-14)

6.4.2 Delivery Models

This section describes aspects of Primes' delivery models in relation to: NHS partnerships; healthcare professional roles; subcontractors; and assessment and claimant journeys.

NHS partnerships

Primes' proposals were encouraged by DWP to reflect the needs of claimants in a CPA demonstrate awareness of local provision to avoid duplicating services and develop partnerships (DWP 201 Oe). Therefore, it was pertinent to examine how Primes considered the health needs of claimants within their CPA and any proposed plans for working with local NHS services. It was common for the Primes' bid documents to make reference to local claimants' needs. However, it was not apparent from the level of detail provided, whether and how any local

NHS provision might be addressing these. For example, Ingeus (2011), in reference to the East Midlands, documented that:

'The proportion of residents in the region with a long-term health condition is higher than the national average and adult obesity rates are the highest of any English region. To help address these issues, we will provide a Health & Wellbeing Service delivered by trained professionals and make referrals to our ACE Network of specialist providers...'

(Ingeus 2011, p22).

Similarly, A4e (2011) stated they identified that 46% of the IB/ESA claimants within their CPA would have musculoskeletal conditions and they would address these needs with condition management. A4e (2011) also indicated that they *'...anticipate supplementing existing mental health provision...'* (A4e 2011, p55), because they expected a high demand for these services which were unlikely to be met by the local Primary Care Trust (PCT). It is beyond the scope of this review to confirm whether Primes' presentation of information relating to any local patterns and inequalities in health was correct, but this information illustrates how their choice of provision was justified.

Table 6.3 provides an overview of the Primes' statements about NHS partnerships and engagement. Primarily, this table focuses on statements that were outlined in section 7.1 of the bid documents (which specifically asked for details about local stakeholder engagement), but it also takes into account statements related to working with the NHS in other sections of the bid document. As shown, half of the Primes indicated they had a connection with the NHS, which was developed through an existing programme or their supply chain. For example, Serco (2011) highlighted that one of their subcontractors (Yes2Ventures) had links with GPs.

Table 6.3 suggests that it was more common for Primes to plan to consult with NHS stakeholders when designing their programme, rather than considering the co-location or commissioning of services at the bidding stage. Primes' initial and ongoing involvement with NHS stakeholders shows that claimants' health needs were considered to be important, and that such partnerships were seen to add value to their programme. My interviews and observational work at practice level found little evidence to show that local NHS organisations/trusts had established partnerships with Work Programme provider organisations.

However, one Work Programme manager highlighted strategic level discussions that were taking place between a Prime and a local NHS provider organisation:

"I know that (our prime provider organisation) have recently, and sort of tried to open that, tried to open that conversation, we probably, we probably do that on a micro level, on a case by case basis, you know, we will, our health professionals will have contact with GPs and refer to other services where necessary in relation to a customer case, but on a global level, no."

(Programme Manager- in-depth interview).

Table 6.3 Summary of Primes' bid statements (2011) in relation to proposed NHS partnerships and engagement strategies

Prime	Existing NHS relationship either	Initial talks with NHS to develop links and	To have or to continue engagement with the	Co- location of services with NHS	Align services with NHS	Co- commission NHS services	Other statements
A4E	/	/	/	/	/		
AVANTA				/			
BEST (now Interserve)	/		/				
CDG (since merged with Shaw Trust)	/		/				
EOS (formerly Fourstar)		/					
ESG		/	/				
HOLDINGS							
G4S		/	* /				
INGEUS				/	/	/	
JHP			/				/
TRAINING							
MAXIMUS	/		/				
NCG			/				/
PERTEMPS	/		/				
PROSPECTS	/				/		
REED	/	/	/				
REHAB							/
SEETEC	/	/	/				
SERCO	/				/		
WORKING LINKS							/

NOTE: / Relates to section 7.1

Some Primes stated more general plans to have ongoing engagement with known stakeholders which may include the NHS.

To join with NHS services.

/ To provide in-house space for NHS trainers to deliver their services. Welfare Advisor to broker links with specialist agencies such as health support provider organisations.

/ Nothing identified that was specific.

/ Will work with health/ specialist provider organisations.

Participant observation and informal ethnographic interviews with NHS stakeholders, at welfare-to-work events and in conversations with healthcare professionals and NHS managers revealed an expectation for Work Programme provider organisations to pay, or contribute towards paying, for NHS provision that claimants' access. However, a distinction between what might be classed as 'mainstream healthcare as opposed to 'work focused' healthcare was rarely acknowledged. This seemed to be a grey area which was also highlighted earlier in my analysis of Primes' descriptions of health-related support. It is unclear whether these NHS stakeholder views indicated a lack of understanding about the Work Programme policy. However, a number of key questions are raised about who is, and should be taking responsibility for paying for and supporting claimants' health.

Conversations with NHS stakeholders also revealed their concerns and limited confidence in Work Programme provider organisations being able to support the health of their patients, especially those with mental health problems. For example, when I asked a senior NHS manager about any plans to work with the Work Programme, it was felt there was a need to understand what support was being offered, and to ensure that NHS patients would not come to any "harm". In relation to other areas of programme delivery, Personal Advisers mentioned their struggles to access NHS provision and work together with frontline NHS staff.

"...the only kind of outside, anybody that we ever speak to are support workers, and that's very few and far between that we ever speak to anybody, or maybe if they live in a sheltered accommodation or anything like that, but in regards to doctors or nurses or mental health workers, nothing. I have got one customer whose mental health worker comes with her, but that's only because she can't leave the house, but he sits there and he doesn't speak about, he doesn't have any impact on the interview at all, so we tend to not, nobody contacts us, and then the other side, if we tried to contact them they won't speak to us, data protection, it's very hard, we're like in a box on our own that nobody wants to talk to us."

(Personal Adviser- in-depth interview).

There was little evidence from my empirical work in practice settings to indicate that NHS referral pathways were established to allow Personal Advisers to make direct referrals. However, there appeared to be some progress towards achieving this in one Prime. To help support Personal Advisers' practice this

organisation's partnership manager was trying to establish links with local NHS services. Difficulties in making referrals to NHS services were also experienced by Work Programme healthcare professionals who were working for one organisation. However, another healthcare professional practicing in a different CPA did not find this to be a problem.

"... and then in other areas like advisers have come to us with customers who've been, not appropriate for us, just because their condition's too severe, but then we've been able to either advise them that yeah, this person needs this kind of support, you know, they need acute mental health support really for that kind of stuff, or you know, they need to go through, you know, a triage service for, you know, you know, community mental health support, and either we... sometimes, like (name of place) for example, we can do it because, because we're health professionals, you can only refer in if you're health professionals, so they're not used to it but we can actually refer in."

(Healthcare Professional Condition Management Programme- in-depth interview).

This example suggests that there are local differences in whether NHS services perceive Work Programme healthcare professionals to be considered part of the NHS referral chain or to be credible as those who are employed by the NHS. It also questions whether the NHS may be unwilling to support the costs of providing services to claimants in the absence of any funding from the Work Programme. Therefore, there is likely to be patchiness with local variation particularly given the restructuring of the NHS commissioning arrangements. Thus, any difficulties with NHS services are likely to be linked to different commissioning models and payment and monitoring arrangements, as well as to management practices within different services. For instance, a service that receives a block contract might be more able to accommodate additional referrals than one that is paid on a 'per case' basis where there would be a need to conform to strict referral mechanisms so that money flowed to meet the costs of provision. These factors were beyond the scope of the current study, but are worthy of future investigation.

Having a consistent approach across work and health services was a key recommendation in the Perkins, Farmer and Litchfield's (2009) independent review, as highlighted in Chapter Three, but a lack of integration between the NHS and the Work Programme was found in my in-depth interviews, participant

observation of the wider welfare-to-work arena, as well as largely vague statements in the bid documents. This limitation, also found in practice through my empirical research, could make it particularly difficult for Personal Advisers to gain a better understanding about claimants' health circumstances, and to respond effectively. This is described in Chapter Seven.

Healthcare professional roles

In-house healthcare professional roles were not commonly proposed, as only four out of the 18 Primes' bids documented these. The overview of these roles is presented in Table 6.4. Despite different titles - Health Advisor, Health Consultant, Occupational Health Coach and Work Health Expert, further examination of these roles suggested that they all have a similar combined work and health focus. International evidence and experience was referred to in the design of three of these roles (Maximus 2011, A4e 2011, EOS 2011). As shown in Table 6.4 three of these roles also have a specific requirement to support Personal Advisers (Ingeus 2011, A4e 2011, Maximus 2011). However, as only four of the 18 Primes actually proposed such a role this seemed to be a low priority among the majority of Primes.

It is not yet known how many of these in-house roles are available in practice, or how many Personal Advisers have access to this level of support, but my primary data collected at practice level and wider observation of the practice arena suggests that in practice the total number of healthcare professionals employed within a CPA may be low. For instance, a number of stakeholders consulted reported that only one or two healthcare professionals were practicing in a Prime within a CPA. One CPA may support for example, 93,680 claimants who receive incapacity benefit (IB) and Severe Disability Allowance (Pertemps 2011). Further evidence of the limited number of these in-house posts comes from my review of job advertisements. For example, EOS' job advertisement, for a Work Health Expert, stated that the healthcare professional would be '*Lone working [across] 5 sites*' in the Black Country and Birmingham (Equal Approach 2013). This also suggests that some in-house healthcare professionals may work autonomously with limited access, if any, to peer support or clinical supervision. These aspects have been shown to be valued by healthcare professionals who worked within the PtW CMP (Barnes and Hudson 2006b, Nice and Davidson 2010). Thus, the prospect of lone working

may discourage healthcare professionals from applying for these roles or could affect their retention. This emerging picture also raises questions about the quality and adequacy of the practice provided.

More notably in practice, these in-house positions appear not to be being made accessible to all Personal Advisers. For example, one Personal Adviser who was interviewed had previously worked for one of the Primes that proposed having an in-house role reported that no such provision was available in practice. Although it was not possible to clarify exactly why this might be the case, this example does highlight how Primes' promised delivery might not come to fruition. It is not clear whether this example would be classed as a breach of contract or not, for instance, if an in-house healthcare professional role was not specifically outlined within a Primes' MSLs, or if any issues of inadequacy of this provision will be monitored by DWP.

Despite the apparently limited provision of Work Programme healthcare professional roles, I found two examples through my practice observations and participant observations in the wider welfare-to-work arena. These observations suggested a new healthcare professional role - a hybrid role - integrating some of the dimensions of a Personal Adviser with that of a healthcare professional. In one Work Programme organisation this role had been informally innovated by an employee, who was an Occupational Therapist. At a welfare-to-work conference this therapist explained that although she was not employed as a healthcare professional, she regularly provided health-related interventions. In another case, this dual type of role was evident when a healthcare professional was primarily employed by a Work Programme subcontractor to deliver CMP, but was also tasked with supporting welcome inductions and one-to-one appointments that were typically carried out by Personal Advisers. However, this aspect of her role had decreased over time as the organisation's work load increased.

High salary costs associated with employing healthcare professionals were clearly a concern to some Work Programme managers. Therefore, their services needed to be used carefully;

"I think one of the difficulties is that the health professionals that I employ, or that I pay, cost twice as much as the people who aren't health professionals, if the name of the game is getting people into work, and if I

can pay twice as much to get half as much back, that doesn't make any sense in Work Programme terms, so therefore it's really about using health professionals sparingly and wisely..."

(Programme Manager- in-depth interview).

However, in contrast I also found an example where a healthcare professional's salary costs were justified in practice, because some Personal Advisers (in one programme) were struggling to support claimants. However, in this example, knowing how to employ a healthcare professional was unfamiliar, hence this organisation was seeking guidance on this matter. Other factors that related to employing healthcare professionals included the need for "*confidential spaces*" where they could work with claimants.

Staff ratio	Unknown.	Unknown. Plus 1 secondee from Rehab Works.	A team. Number unknown.	claimants' hours of work.
Salary (2012- 2013) According to geographical area	£25,000*.	£30,000-£34,000*.	Physical Health Advisor £23,985 Mental health Advisor £23,985-£29,165*.	Unknown. Mobile team. Not identified.
NOTE: * Internet job description. Total Jobs (2011) Equal Approach (2013 a/b). *Likely to be comparable to the NHS Agenda for Change banding.				

Clarifying whether provider organisations' (Prime or subcontractor) health-related support would be delivered by healthcare professionals, or someone else, was not always possible. For example, Prospects (2011) stated that they will provide '*Well Being Groups*,' but it was not clear who would deliver these (Prospects 2011, p11). In some cases, it was helpful to carry out further investigations of subcontractor/partner provider organisations' websites. This helped to identify the healthcare professional roles that might be involved, for example, A4e's bid (2011) stated that they will provide:

'Specialist health support including a specialist health assessment from Advanced Personnel Management (APM)...'

(A4e 2011, p11).

When AMP's website was reviewed, it stated that the health assessments and related interventions would be conducted by '*qualified Allied Health Professionals*' (AMP 2011).

Overall a range of healthcare professional roles were identified within the bid documents, but there were unanswered questions about how some of this provision, (in-house and external led) would be provided. This suggests that some provider organisations may have opted to address claimants' health-related needs with non clinical staff. This approach is also found in NHS services¹³. The use of non clinical staff was also evident within some of the PtW CMPs as shown in Chapter Three. Although this approach was not necessarily considered to be ineffective, models of supervision were also reported within these programmes (Nice and Davidson 2010). Supervision structures may not be available within the Work Programme. Therefore, there may be risks to claimants' health that may go un-detected. This raises a set of questions relating to value for money, as cheaper models may not be as cost effective if outcomes are poor.

Subcontractors

Although many of Primes reported to both directly deliver interventions and subcontract for elements of their overall programme, two such organisations, Serco and G4S, have adopted an entirely management role, overseeing a

¹³ For example, health trainers being employed to provide general health support and advice with a particular focus on healthy lifestyles and complement services of primary and secondary care.

supply chain of subcontractors. Therefore, the percentage of delivery split between a Prime and their supply chain varied. For example, Prospects (2011) documented that they will deliver 31 percent and Working Links (2011) 78.6 percent.

DWP (2011 e) described subcontractor supply chains as tier one, or two, but explained that the definitions of these were not necessarily consistent across Primes. While supply chains were expected to change over the lifetime of the Work Programme, in order to reflect local needs, DWP (2011e) maintained that they will ensure Primes' service offers were not compromised. DWP (2011e) also expected Primes to use other suppliers to offer *one off, unique interventions in response to a particular participant's needs and circumstances'* (p1). All of the Primes proposed the use of a range of specialist provider organisations within their bid documents and many of these were indicated to be used if, and when claimants' needs arise. Table 6.8 presented in 6.5.4 shows a variety of provider organisations that were documented to deliver CMP. Annex 2 of the bid documents provided further details about these proposed organisations and their expected percentage of delivery. When these annexes were reviewed, a range of subcontractor types, both private and third sector, were identified and these included end to end and ad hoc/spot purchase. However, some details could not be clarified. For example, Avanta (2011) stated that Shaw Trust will deliver CMP, but this was identified to be via an end to end subcontractor (called South Tyneside Ten). South Tyneside Ten were documented to have two percent of Avanta's overall delivery. Therefore, it was not possible to clarify the percentage of delivery that would constitute Shaw Trusts' CMP. This also suggests that there was a lack of concern and attention to scrutinising the adequacy and quality of health related-support provision on the part of DWP commissioners. Some Primes were indicated to operate as subcontractors for other Primes. When exploring the implications of this, it was identified that different service offers to claimants existed within the same provider organisation.

My practice level observations and research interviews suggested that while health provider subcontractor organisations were important to Primes, at the bidding stage they could be reluctant to support the associated costs in practice once in delivery mode:

"We'd met up with [prospective Primes] and they were really sort of, yeah, keen to meet up with us, but then when we met with them we sort of, it became clear that they wanted our service, but they didn't want to pay for it, they wanted us to be funded magically from somewhere, and they could have, and include it in their bid and not pay for it..."

(Healthcare professional Condition Management Programme- in-depth interview).

In addition, a conversation with a manager of a health-related provider organisation, who had been included in a Prime's bid, revealed that no referrals had been received almost a year after the Work Programme had been operational. Similarly, the NCVO (2011) identified that some tier two provider organisations (voluntary sector) had not received any referrals. These types of contracting issues were presented to the House of Commons Work and Pensions Committee in (2011b). Here, *'witnesses were concerned that voluntary sector organisations could be used to "window dress" bids to make them appeal to DWP at the tendering stage but would then be used sparingly, if at all, in the actual contract delivery* (House of Commons Work and Pensions Committee 2011b, p17). The term *"bid candy"* was also mentioned by (Taunt 2011, p17) in relation to this in this report. The examples provided suggest that there was some evidence of this in relation to health-related support.

Assessment and claimants' programme journey

Earlier work has highlighted the way in which provider organisations' use of claimants' assessments varies across welfare-to-work provision (Coleman and Parry 2011). Such variability was also evident within the Work Programme models. Assessments described in the bid documents included: initial, ongoing, pre work and in work. Some of these assessments have been designed in-house with input from occupational psychologists e.g. A4e (2011), or past programme experience. More than half of the Primes had experience of delivering programmes to claimants who have health-related needs, for example, PtW and New Deal for Disabled People. Therefore, it is likely that these organisations will have extensive experience and knowledge about what they consider will meet claimants' needs.

Table 6.5 provides an overview of the initial assessments, who was identified to perform these, and whether claimants' health-related barriers/needs were made explicit. As shown in Table 6.5 some Primes proposed to engage in a form of claimant triage (with an initial telephone screening assessment undertaken by a customer service representative), prior to allocating a Personal Adviser. Ten out of 18 of the initial assessments made explicit reference to health. Some of these screening assessments require claimants to discuss their health condition with this representative (e.g. Best). Thus, there is an assumption that claimants will not only disclose their health information, but that their revealed details can then assist decision making, and allocation of a provider organisation and/or Personal Adviser.

Table 6.5 also shows that Personal Advisers were indicated to have a significant role and responsibility for carrying out, or overseeing assessments. Therefore, Personal Advisers will need to help claimants communicate their health-related needs, and determine whether a specialist health assessment and/or support are required. This highlights the importance of provider organisations ensuring that Personal Advisers are adequately prepared for these tasks, which can be challenging, as shown in Chapters Five and Seven. It also illustrates their key gatekeeper and enabler roles (as discussed in Chapter Five) in being able to support claimants' access to specialist provision and encourage participation.

Specialist health-related assessments: initial, pre work and in work were also documented in some of the bid documents. In general, the bids stated that these assessments were to be accessed at the discretion of a Personal Adviser, but in some cases a claimant was also indicated to be able to request these, e.g. Avanta 2011. It was not possible to determine the nature or effectiveness of these specialist assessments, but it was proposed that healthcare professionals, both in-house and externally would have some involvement as shown in Tables 6. 5 and 6.6.

Table 6.5 Primes' bid statements (2011) in relation to claimant assessment process

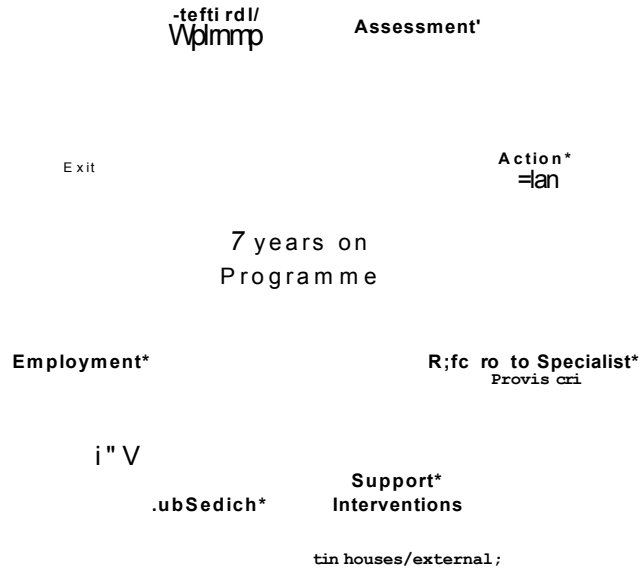
Primes' bid statements	Claimant assessment process	Primes' bid statements	Claimant assessment process
<p>1. ಮಾನ್ಯತೆ</p> <p>2. ಪ್ರತಿಭೆ</p> <p>3. ಪ್ರತಿಭೆ</p> <p>4. ಪ್ರತಿಭೆ</p> <p>5. ಪ್ರತಿಭೆ</p> <p>6. ಪ್ರತಿಭೆ</p> <p>7. ಪ್ರತಿಭೆ</p> <p>8. ಪ್ರತಿಭೆ</p> <p>9. ಪ್ರತಿಭೆ</p> <p>10. ಪ್ರತಿಭೆ</p>	<p>1. ಮಾನ್ಯತೆ</p> <p>2. ಪ್ರತಿಭೆ</p> <p>3. ಪ್ರತಿಭೆ</p> <p>4. ಪ್ರತಿಭೆ</p> <p>5. ಪ್ರತಿಭೆ</p> <p>6. ಪ್ರತಿಭೆ</p> <p>7. ಪ್ರತಿಭೆ</p> <p>8. ಪ್ರತಿಭೆ</p> <p>9. ಪ್ರತಿಭೆ</p> <p>10. ಪ್ರತಿಭೆ</p>	<p>1. ಮಾನ್ಯತೆ</p> <p>2. ಪ್ರತಿಭೆ</p> <p>3. ಪ್ರತಿಭೆ</p> <p>4. ಪ್ರತಿಭೆ</p> <p>5. ಪ್ರತಿಭೆ</p> <p>6. ಪ್ರತಿಭೆ</p> <p>7. ಪ್ರತಿಭೆ</p> <p>8. ಪ್ರತಿಭೆ</p> <p>9. ಪ್ರತಿಭೆ</p> <p>10. ಪ್ರತಿಭೆ</p>	<p>1. ಮಾನ್ಯತೆ</p> <p>2. ಪ್ರತಿಭೆ</p> <p>3. ಪ್ರತಿಭೆ</p> <p>4. ಪ್ರತಿಭೆ</p> <p>5. ಪ್ರತಿಭೆ</p> <p>6. ಪ್ರತಿಭೆ</p> <p>7. ಪ್ರತಿಭೆ</p> <p>8. ಪ್ರತಿಭೆ</p> <p>9. ಪ್ರತಿಭೆ</p> <p>10. ಪ್ರತಿಭೆ</p>
<p>11. ಮಾನ್ಯತೆ</p> <p>12. ಪ್ರತಿಭೆ</p> <p>13. ಪ್ರತಿಭೆ</p> <p>14. ಪ್ರತಿಭೆ</p> <p>15. ಪ್ರತಿಭೆ</p> <p>16. ಪ್ರತಿಭೆ</p> <p>17. ಪ್ರತಿಭೆ</p> <p>18. ಪ್ರತಿಭೆ</p> <p>19. ಪ್ರತಿಭೆ</p> <p>20. ಪ್ರತಿಭೆ</p>	<p>11. ಮಾನ್ಯತೆ</p> <p>12. ಪ್ರತಿಭೆ</p> <p>13. ಪ್ರತಿಭೆ</p> <p>14. ಪ್ರತಿಭೆ</p> <p>15. ಪ್ರತಿಭೆ</p> <p>16. ಪ್ರತಿಭೆ</p> <p>17. ಪ್ರತಿಭೆ</p> <p>18. ಪ್ರತಿಭೆ</p> <p>19. ಪ್ರತಿಭೆ</p> <p>20. ಪ್ರತಿಭೆ</p>	<p>11. ಮಾನ್ಯತೆ</p> <p>12. ಪ್ರತಿಭೆ</p> <p>13. ಪ್ರತಿಭೆ</p> <p>14. ಪ್ರತಿಭೆ</p> <p>15. ಪ್ರತಿಭೆ</p> <p>16. ಪ್ರತಿಭೆ</p> <p>17. ಪ್ರತಿಭೆ</p> <p>18. ಪ್ರತಿಭೆ</p> <p>19. ಪ್ರತಿಭೆ</p> <p>20. ಪ್ರತಿಭೆ</p>	<p>11. ಮಾನ್ಯತೆ</p> <p>12. ಪ್ರತಿಭೆ</p> <p>13. ಪ್ರತಿಭೆ</p> <p>14. ಪ್ರತಿಭೆ</p> <p>15. ಪ್ರತಿಭೆ</p> <p>16. ಪ್ರತಿಭೆ</p> <p>17. ಪ್ರತಿಭೆ</p> <p>18. ಪ್ರತಿಭೆ</p> <p>19. ಪ್ರತಿಭೆ</p> <p>20. ಪ್ರತಿಭೆ</p>

Prime	Initial assessment process	Health barriers mentioned	Initial assessment carried out by	Initial health assessments available through filtering process*	Health assessment carried out by
ESG HOLDINGS	Diagnostic assessment tool. 2 part assessment: an online psychometric questionnaire and structured interview.	✓	Trained qualified assessor. Personal Adviser.	X	X
EOS (formerly Fourstar)	Market tested diagnostic. The Work Star and own diagnostics.	Not clear mentioned assessment of 'stability' (p 10).	Personal Adviser.	In-depth assessment of work capability.	In-house Work Health Expert role.
G4S	Diagnostics.	✓	Personal Adviser.	Specific needs assessment tools such as Mental Health First Aid and Hidden Disabilities Diagnostics.	Subcontractor Advisors; Mind and Dyslexia Action.
INGEUS	Online self-diagnosis tool. Diagnostics.	X	Claimant with guidance from Personal Adviser.	Where identified as relevant to assess workplace capabilities. Indicated to be identified from a claimant's Work Capability Assessment report.	In-house healthcare professionals.
JHP TRAINING	Bespoke screening tool and further in-depth assessment. Assessments available on-line, face-to-face or via telephone. This identifies any needs for further assessments.	✓	Customer Service Administrator then Personal Adviser.	X	X
MAXIMUS	Initial screening with self assessment online where	X	Claimant Personal	Claimants who are identified as having 'serious health issues'	Mobile Health Consultant led via

Prime	Initial assessment process	Health barriers mentioned	Initial assessment carried out by	Initial health assessments available through filtering process*	Health assessment carried out by
	possible. 1:1 with an Employment Consultant using a series of questions and scenarios, and web-based assessment tool, or with a Health Consultant.		Adviser.	which limit their ability to get a job (p14).	the in-house health team.
NGG	Continuous assessment: personalised, psychological and motivational intervention over two days. Then an employability assessment.	✓	Personal Adviser.	X	X
PERTEMPS	Employability Diagnostic and identifying further diagnostic assessment.	X	Personal Adviser.	Enhanced assessments indicated such as mental health assessments.	Specialist partner organisations.
PROSPECTS	Initial assessment by phone than a face-to-face assessment.	✓	Personal Adviser.	X	X
REED	Diagnostics Tool and progression model.	X	Personal Adviser.	X	X
REHAB	Specialist assessments conducted in different situations including groups.	✓	Personal Adviser.	X	X

Prime	Initial assessment process	Health barriers mentioned	Initial assessment carried out by	Initial health assessments available through filtering process*	Health assessment carried out by
SEETEC	Assessment face-to-face or telephone/online. Online self assessment questionnaires followed by solution focused interviewing.	✓	Personal Adviser.	X	X
SERCO	In-depth assessment process.	✓	Personal Adviser.	X	X
WORKING LINKS	Diagnostic assessment.	✓	Personal Adviser.	X	X
NOTE: X= not identified in bid document. ✓ = identified in bid document. * Excludes statements that related to specialist assessments which could potentially include health.					

Figure 6.2 Generalised Work Programme Journey



All of the Work Programme journeys described in the bid documents differed, but there were similar claimant stages and processes regardless of benefit type. The programme stages ranged from three (e.g. Serco 2011) to six (e.g. Maximus 2011). The minimum frequency of claimants' appointments ranged from every two weeks (e.g. Seetec 2011) to once a month (e.g. A4e 2011). A generalised Work Programme journey was conceptualised to illustrate typical programme stages. This is presented in Figure 6.2. As shown, health-related interventions might be offered at the following stages, assessment, action planning, job search and pre employment and post employment. It is important to note that Primes' programmes may not necessarily follow the flow shown, and the speed in which claimants may reach these stages could vary according to their needs (e.g. Seetec 2011). In addition, some Primes indicated that they would increase their involvement with claimants who were some distance from moving into work (e.g. Rehab 2011).

One healthcare professional (who was involved in the Work Programme) felt there was a greater need for a healthcare professional's expertise at the assessment stage. However, it is not known if this new empirical finding is a common theme.

"...I would like to be in a little bit earlier, because obviously referral, welcome, they've got to get sent to someone that's gonna be able to offer them support, but I would like to be around the assessment, because theoretically, and this is not personal or detrimental to anyone else's, the assessment is really important, because theoretically can't make an action plan and refer to specialist provision unless you do the assessment correctly, and you know, job advisers are experienced and in the know about job advising, but they're not experienced in doing a proper health assessment, both psychological and physical, and I think sometimes a lot of people get lost in this area, and theoretically, if you do a proper assessment you can't carry on, well you can carry on, but whether they're receiving the right support or not, and this is only my personal opinion. So I would like to see, a mixture of different types of assessment, and, and a health related benefit assessment should theoretically, in my opinion, be done by a health professional, so I'd like to see us there, we are actually there, and even the referral to specialist provision, again I think you need some, have some health education, knowledge, or be a health professional to be able to refer to specialist provision, and I'm not saying that the people that are doing the job now are not good or are not caring, but I would think that they haven't got the bit the baseline background to be able to do that..."

(Healthcare professional Condition Management Programme- in-depth interview).

6.4.3 Personal Advisers

All of the Primes outlined a type of Personal Adviser role which was typically described as central to supporting claimants' progress into, and sustainment in work.

Continuity of support

The extent to which a Personal Adviser was indicated to stay with a claimant across the whole journey varied across Primes. Fourteen Primes showed a preference for a continuity type of Personal Adviser model. This model aimed to ensure that a claimant was allocated to a "dedicated" Personal Adviser. Some Primes referred to this as a "case management" type role for example, CDG (2011). In contrast, a split Personal Adviser model, which was adopted by Serco, intentionally aimed to ensure that claimants changed Advisers during their Work Programme journey.

'Evidence suggests that transitions are effective in challenging comfort zones, introducing a new Adviser with a fresh approach and keeping Jobseekers focused on the objective of sustained employment This extra impetus is lost when a single Provider delivers an end-to-end service'

(Serco 2011, p17).

Types of roles

A range of Personal Adviser role titles were identified. This is common in the welfare-to-work sector (McNeil 2009). I have broadly categorised the roles that were identified in the bid documents into three types: stage-specific, speciality and specialist health trained as shown in Table 6.6. Although there were similarities across the bid documents, the Personal Adviser's role was not indicated to be standardised as both Primes and subcontractors proposed different types.

Table 6.6 Primes' bid statements (2011) in relation to Personal Adviser roles

Prime	Sequence	Specialist	Specialist health trained
A4E	/ Who have specialist skills.	/ Specialist Advisors. Trained to help people in all customer groups.	
AVANTA	/		
BEST (now Interserve)		Sector specific.	
CDG		/ In-depth knowledge of specialist groups.	Ongoing investigation of training packages, including in-house training on mental health awareness for all frontline staff. / All customer-facing staff receives disability awareness training.
EOS (formerly Fourstar)			
ESG HOLDINGS			
G4S			
INGEUS		/ To work with people in receipt of health benefits.	/ EAs (Trained to work with claimants with a health condition/disability).
JHP TRAINING	/	/ In-Work Coach: trained by occupational psychologists.	
MAXIMUS			
NCG			
PERTEMPS			
PROSPECTS	/	/	/ CBT trained.
REED			Trained to help make transition into work.
REHAB			Staff training on how to deal with vulnerable claimants.
SEETEC			
SERCO		Specialist training to all frontline staff.*	»
WORKING LINKS			/ To identify core health issues. For staff across the supply chain.

NOTE: EA referred to a type of Personal Adviser *Unknown if included health-related.

The stage specific role appeared to be allocated when a claimant reached a certain programme stage. An example of this type of model was evident in Avanta's (2011) bid document which stated that:

'[A claimant's] journey is based on three types of support; Employment Consultants who will assess needs and plan the journey, Job Coaches, who will support preparation into work and Career Coaches, who will deliver in work support'

(Avanta 2011, p11).

A variety of specialist roles were identified, in the documents, but it was difficult to clarify the exact nature of their expertise in some cases. For example, JHP (2011) stated that:

'...customers [with a specialist need] will be referred to in-house Specialist Coaches who will provide in-depth assessment and specialist support. Specialist Coaches will have expertise on specific customer requirements (e.g. Housing) or customer groups (e.g. Lone Parents)...'

(JHP 2011, p14).

In contrast, BEST's (2011) specialist roles were indicated to be sector specific which was quite different to the other roles identified. Health specialist Adviser roles were indicated to work with certain groups of claimants i.e. those in receipt of health benefits (e.g. Ingeus 2011). Some of these Personal Advisers were likely to work in collaboration with healthcare professionals as shown in Table 6.4. The range of Personal Adviser roles proposed suggests that, in practice, some claimants are likely to receive support from a number of Personal Advisers. It is also likely that a claimant may experience a combination of Personal Adviser support if they are involved with a Prime and specialist subcontractor provision. Consequently, it is likely that both Personal Advisers and claimants will need time to establish a trusting relationship when a new Personal Adviser is allocated and to understand the role and remit of each Personal Adviser. Establishing rapport has been shown to be important and is pertinent during assessment stages (as shown in Chapter Five), as this can support a claimant's health disclosure and identification of any health-related barriers to employment (Coleman and Parry 2011).

My practice observations and interviews found that claimants could experience a change of Personal Adviser, for example when they participated in a job club. In practice one of the disadvantages of changing or having different Personal

Advisers was that claimants' health-related information may not necessarily be passed on to their new adviser.

Preparedness to respond to claimants' health-related needs

In terms of preparing and equipping Personal Advisers to respond effectively to claimants' health-related needs, some Primes such as EOS and Working Links, indicated that they will provide all Personal Advisers with health-related training, as shown in Table 6.6. However, the extent to which Primes' training will prepare and equip Personal Advisers to support claimants' health-related barriers was difficult to assess. It appeared that some Primes may only offer specific health-related training to Personal Advisers who were considered to have a more specialist role, as shown in CDG's and Ingeus's models. This could limit the support that a claimant with a health-related need receives from their Personal Adviser. For example, if a claimant receives JSA and has recently received Incapacity Benefit or ESA they may be likely to have health-related needs as shown in Chapter Seven. My practice interviews found that Work Programme Personal Advisers who worked with claimants (JSA and ESA) had received some health-related training from their organisation. This is discussed further in Chapter Seven.

Personalising practice

Tailoring of support was repeatedly echoed in the bid documents, with the Personal Adviser being perceived as a key agent who could ensure that services were personalised: *'Having a named [Personal Adviser] across the journey is the lynch-pin for ensuring a personalised service'* (Working Links 2011, p16). Proposing this type of support is not surprising given DWP's (2010e) requirement for Primes to ensure that they tailored support to meet individuals' needs. However, one of the risks identified in Table 6.1 concerned how increased caseloads might impact on the amount of time that Personal Advisers could spend with a claimant and the consequent limits to their ability to tailor support. Importantly, only one Prime, G4S (2011), gave an indication of the expected number of claimants a Personal Adviser would have in total on their caseload in their bid document: *'Each has a caseload of no more than 80 individuals'* (G4S 2011, p14). In practice, my interviews revealed that some caseload numbers were much higher and several Personal Advisers reported that this did limit their ability to devote sufficient time with claimants.

"It's about 180 at the moment, and that's about, really you should, what we were told when the Work Programme came around is that we'd have (...) about 45 to 50 customers on our active caseloads, which was, which was good, because we're contracted to meet them once a fortnight, we have to have that face-to-face engagement once a fortnight, and it just doesn't happen at the moment. But that would be, well I mean with that as well, we could actually have customers for an hour, an hour and a half if we wanted to, at the moment you have a 30 minute window, and if the customer's 10 minutes late then you're right, what have you applied for, [take a photocopy of it], right, here's your next appointment, we'll see you in a bit."

(Personal Adviser- in-depth interview).

However, there were many examples during my observations where I found that in practice Personal Advisers' one-to-one sessions provided holistic and personalised support to help claimants address a wide range of complex issues. Many of these issues were not directly related to claimants' health or work, for example, housing problems.

Enforcer role: conditionality

Overall, Primes were clear about conditionality within their bid documents, and outlined their intentions to ensure that claimants were made aware of their responsibilities and obligations to meet their benefit entitlement. From a health perspective, there was no indication in the bid documents to suggest that Primes intended to use elements of conditionality to enforce claimants' participation in health-related support interventions. However, there were some expectations for claimants to engage in work related activities such as a work trial as shown in Table 6.8 in section 6.5.4.

One Prime, G4S (2011), made explicit reference to indicate when conditionality would not be applied for claimants who have health conditions:

'ESA WRAG Customers are able to benefit from compulsory interventions such as attending appointments and attending training as agreed with their Personal Advisor - not including actions relating to undertaking medical treatment, applying for work or taking up employment'

(G4S 2011, p 21).

This would be expected given DWP's (2013b) Work Programme guidance document which stated that:

'When deciding whether activity is reasonable in a participant's circumstances you need to consider: The participant's claimant group and how this affects the nature of their participation. For example, although mandatory ESA participants can be supported towards employment they cannot be mandated to:

- *apply for jobs*
- *undertake medical treatment*
- *take up work'* (DWP 2013b, p6).

An interview with a Work Programme healthcare professional revealed that a minority of Personal Advisers were using conditionality to enforce CMP participation and/or GP consultations.

"...what happened was one particular Personal Adviser on one group mandated like three customers to come..."

(Healthcare professional Condition Management Programme-in-depth interview).

This raises fundamental questions about the Personal Adviser's role boundaries and whether there might be any adverse consequences arising from enforcing claimants' attendance at a health-related support. In addition, it highlights the extent to which a Personal Adviser may use their 'enforcer' role dimension, which was described in Chapter Five. Interestingly, two of the Work Programme healthcare professionals who were interviewed stated they were willing to work with mandated claimants. This raises further questions about the effectiveness of a health-related provision (CMP) that was primarily designed to assist claimants who had volunteered to participate (Randall 2012). In addition, voluntary participation within the PtW CMP was reported by CMP practitioners (in one study) to be important for claimants' engagement (Barnes and Hudson 2006b). Moreover, mandating claimants to a health-related support provision poses potential ethical dilemmas and challenges for healthcare professionals who deliver these programmes because they have to abide by a code of conduct and gain individuals' consent when providing interventions. It is evident that there were different types of Personal Adviser roles and models of Work

Programme delivery. Some Personal Advisers are therefore likely to be more prepared and equipped to work with claimants who have health-related needs than others. This raises questions about their competency to engage in their enabler and enforcer roles as discussed in Chapter Five.

6.4.4 Health Interventions: Condition Management

The types of health-related support interventions described within the bid documents were varied and diverse. These were to be provided directly by the Prime, a specialist subcontractor or by facilitating claimants' access to existing statutory health-related provision (e.g. A4e 2011, Avanta 2011, Reed 2011, Rehab 2011, Seetec 2011). 'Condition management' was a prominent descriptive term used by 15 Primes as shown in Table 6.7. Primes that did not specifically use the term 'condition management' also documented types of health-related support as shown in Table 6.7.

Health-related support varied amongst Primes, but the bids included: specialist health assessment (as shown in Table 6.4 and 6.5) with a focus on identifying functional capability and job matching. Interventional approaches included: Cognitive Behavioural Therapy (CBT), solution focused therapy, counselling and motivational interviewing techniques. What might be perceived as more clinical type interventions, ("hands on") such as physiotherapy were also indicated along with lifting tests. Health management interventions included: advice and guidance (such as pain management techniques), promotion of healthy lifestyles and encouragement of activities such as walking and healthy diets (e.g. Ingeus 2011). Complementary health-related interventions such as yoga and Tai Chi are also proposed by one Prime (EOS 2011). Involvement with employers to explore workplace adjustments were also indicated by some Primes (e.g. A4e 2011). These interventions were to be carried out through group work and /or 1:1, via face-to-face in a range of venues and locations or telephone support services.

Prime	Specific descriptor	Examples of who will deliver provision	Accessibility to claimants
		Company.	
INGEUS	<i>'Specifically designed Health & Wellbeing interventions will be offered to all customer groups in recognition of the fact that many disadvantaged customers experience poor health regardless of their benefit type' (p14).</i>	In-house healthcare professionals.	All claimant groups.
JHP TRAINING	Draw on condition management experience.	Shaw Trust.	Volunteer IB/IS.
MAXIMUS	Condition management.	Local network of specialist providers e.g. Shaw Trust.	Claimants with serious health issues.
NCG	Condition management.	RehabWorks UK.	Any claimants with health conditions. (This includes chronic conditions).
PERTEMPS	Condition Management Programme.	The Salvation Army.	'Hardest to help' claimants i.e. those with addiction, mental health and health issues.
PROSPECTS	<i>'We are aware that while each customer will have a different combination of barriers and needs, the groups highlight common criteria such as ESA and IB groups requiring support with access to work and advice on managing their condition in the workplace' (p8).</i>	Via specialist partner organisations.	For all claimants.
REHAB	<i>'[Personal Advisers] will also signpost customers to specialist disability support partners such as Agorriad to get extra support in managing conditions' (p17).</i> Specialist support for those with mental health issues.	Local specialist support provider organisations.	IB/ESA.
REED	Condition management Programme.	Reed.	For mild to moderate mental health and muscular-skeletal conditions.
SEETEC	Condition Management Programmes. Condition Management assessments.	Existing NHS services.	Claimants with moderate/severe health conditions/ disabilities.

Prime	Specific descriptor	Examples of who will deliver provision	Accessibility to claimants
SERCO	Condition Management Programme.	Yes2Ventures.	Claimants some distance from the labour market.
WORKING LINKS	CMP.	SALUS qualified nursing staff.	Claimants in Enable phase of programme. JSA Ex-IB.

NOTE: This list of provider organisations presented that were proposed to deliver interventions is not exhaustive. The three Primes that did not explicitly use the descriptor Condition Management have example verbatim quotes to illustrate their health-related support provision. Primes' use of the term customer has been replaced with claimant in the third column. Page numbers were manually inserted into the bid document. Abbreviations: IB- Incapacity Benefit, IS- Income Support.

A comparison between the PtW CMP and the new Work Programme health-related support provision was considered useful to identify any similarities or differences in delivery. In addition, it was of interest to examine whether and how the Work Programme proposals had drawn on past evidence, or sought to innovate. Table 6.8 compares the features and types of interventions offered within the PtW CMP (which was described in Chapter Three) with those identified within the Work Programme bids alongside practice examples found in my practice observations and interviews. As shown in Table 6.8, many of the currently proposed CMP interventions appeared to be similar to the previous PtW CMP as described in Chapter Three, with the exception of interventions that were aimed at addressing the gaps in the Work Capability Assessment (WCA), and those that proposed to provide support for employers. This suggests there has been some development of CMPs, as advocated by Freud (2011b) and highlighted in Table 6.1.

Thus, some Work Programme condition management interventions aimed to not only support claimants' progression towards work, but the overall programme delivery, with a stronger focus on job outcomes and sustainability. This is particularly evident in some Primes' bid descriptions of post CMP employment support, which was not typically available within the PtW CMPs as noted by Nice and Davidson (2010). The Work Programme's in-work support had a focus on supporting both employees and employers. A range of telephone support services for both employees and employers were described by many Primes in their bids. Some of these telephone services were to be delivered externally (by healthcare professionals) and to be made available for people who have moved into work, 24 hours, seven days a week (e.g. A4e 2011) or internally led (e.g. NCG 2011). At practice-level there was little evidence of in-work support from CMPs in the organisations I studied and interviews with a CMP practitioner, although this may have reflected the timing of the study which was conducted during the first year of the Work Programme delivery.

			was being provided by Work Programme healthcare professionals.*
Group work and 1:1 interventions.	Group Work and face-to-face and phone 1: 1 interventions.		Group work, face-to-face/telephone, 1:1 interventions.
Generally non clinical interventions.	Some clinical interventions e.g. physiotherapy indicated.		No clinical interventions described or observed.
Typically generic Condition Management Practitioner role rather than health profession specific particularly in NHS led services.	Range of roles including generic in-house role e.g. Occupational Health Coach role and specific roles such as Occupational Therapist and Physiotherapist		Generic type of healthcare professional role described.
Gateway to Condition Management Programme typically via a Personal Adviser.	Gateway to health-related support via Personal Adviser and specific assessment routes that identify claimants' health needs and barriers to employment.		Gateway typically by a Personal Adviser or triggered by a specific health assessment.
Specially trained Personal Advisers in Jobcentre Plus districts/ varied level of Personal Adviser training in provider organisations.	Variable levels of Personal Adviser training - some had specific specialist roles and health-related training.		A range of provider organisations' health-related training was described by Personal Advisers. Work Programme healthcare professionals also provided training both formally and informally.
Signposting to health services and liaison with GPs.	Some Primes emphasized the use of signposting claimants to existing NHS services.		Personal Advisers were encouraging claimants to see their GP. Use of signposting to Third sector organisations for health-related support interventions.
Partnerships formed with NHS.	Some relationships already established. Opportunities to form partnerships with the NHS explored. Use of specialist health services in Work Programme provider organisations' supply chain.		No evidence of partnerships being established with the NHS. Some discussions at strategic level reported. Designated partnership type role evident to help establish NHS relationships in one Prime.
Cognitive behavioural therapy type interventions typically delivered by healthcare professionals within the Condition Management Programme.	Some types of cognitive behavioural therapy type interventions indicated to be undertaken by Personal Advisers.		One Personal Adviser reported to draw on her own health-related skills and supported claimants who had taken part in a Condition Management Programme to continue to use self help strategies.
Some Condition Management Programme practitioners supported Personal Advisers through co-location of	New in-house healthcare professional roles to specifically support Personal Advisers' practice. Clearer integration between work and health with a		Ad hoc support to Personal Advisers through co-location more typically described.

services.	joined up approach between healthcare professionals and Personal Advisers.	
Less focus on employers.	Specific focus on employers, e.g. health-related telephone support services and healthcare professional involvement.	Telephone helps lines were available for employers.
Typically not job outcome focused.	Clearer job outcome focus. Evidence of specific Vocational Rehabilitation e.g. job matching.	Work Programme healthcare professionals reported to incorporate a work focus within their health delivery models.
Limited focus on employees.	Specific focus on employees in particular with in-work support assessments and support.	Limited focus on employees.* Telephone helps lines were available.
<p>NOTE: * Research conducted during the first year of Work Programme delivery. Therefore, Work Programme provider organisations' job outcomes may be limited, and a need for in-work support services may not be fully evident. Stakeholders' views that were gained through participant observation and informal interviews may not reflect UK wide delivery.</p>		

It is important to note that comparing the PtW and Work Programme health-related support provision suggested some promising innovation which could address some of the limitations and gaps of the PtW CMP provision that were identified in Chapter Three. For example, the offer of bespoke CMP (EOS 2011) suggested that claimants will receive support for a range of health conditions rather than prioritising interventions for musculoskeletal, cardio respiratory and mild to moderate mental health as was the earlier pattern in PtW. Ongoing and longer-term support was indicated through in-work support interventions. There appeared to be further innovation with the inclusion of telephone support interventions which may also reduce claimants' anxieties and concerns about sharing their problems in a group setting and the problems associated with having to travel to venues and support any travel costs upfront which were highlighted as potential barriers in the PtW evaluations (Corden and Nice 2006a, Reagon and Vincent 2010, Nice and Davidson 2010).

6.4.5 Claimants' engagement: 'buy in' and full participation

As this chapter focuses on the meso level, a more detailed exploration of claimants' engagement is presented in the next Chapter which focuses on the micro-level interactions between Personal Advisers and claimants. Therefore, this section describes some of the Primes' common approaches and activities that were to be employed in order to initiate and maintain claimants' engagement.

To initiate claimants' engagement, some Primes stated they would offer 'warm' referrals and handovers. *'A 'warm' handover involves meetings between customers, JCP staff and provider staff, which help to smooth or enhance the transition process'* (Coleman and Parry 2011, p6). Initial communications with claimants via letter and telephone were a common practice proposed to ensure that claimants had not only received programme information prior to their attendance, but were aware of their programme status i.e. mandatory or voluntary.

To minimise attendance failure or non participation some Primes indicated they would provide a telephone call to check to see if a claimant had any questions, access requirements or if a home visit was required (e.g. JHP 2011). Contacting claimants in a timely manner, after receiving a referral aimed 'to achieve buy-in and full participation (A4e 2011a, p9). Welcome inductions, (1:1

or group) were proposed to inform claimants about programmes and to explain their rights and responsibilities of engagement. The bid documents indicated that these sessions included the sharing of the Primes' Customer Charter, MSLs and complaints procedures. Additionally, some Primes indicated these sessions aimed to instil a 'work first' approach and the *'right mindset'* (Reed 2011, p8). Thus, these initial contacts were indicated to establish a form of claimant contract:

'At this initial contact we'll initiate a 'customer contract' to ensure each customer understands what we expect from them and what they can expect from us.'

(JHP 2011, p14).

Some Primes aimed to extend this 'contract' during action planning activities (e.g. JHP 2011) after allocating a Personal Adviser. My practice observations found that some provider organisations struggled to engage claimants to start their programme. In these situations, some Personal Advisers reported they felt that the threat of sanctions was a useful strategy to initiate claimants' engagement, while other Personal Advisers expressed concerns about individuals' health if they applied pressure to attend. One Personal Adviser also reported that her organisation was exploring the possibility of visiting claimants at home if they failed to engage.

6.5 Plausibility of the Work Programme model: reflections on the assumptions and risks

Having described aspects of the Work Programme delivery models, I now consider the patterns of provision identified from the bid documents and my practice-level research, to explore what these might mean in relation to the key risks presented in Table 6.1. I also consider whether Primes' choice of interventional strategies might support or undermine the four key areas of effectiveness which were identified in the logic model presented in Figure 6.1.

6.5.1 Effectiveness of Work Programme delivery model in responding to claimants' health-related needs

Overall the bid documents acknowledged that claimants' health-related needs were important, suggesting that this dimension was considered within their

broad delivery model. However, there were mixed approaches to how much prominence was given, and how Primes proposed to address these. A number of key areas of variation and potential risks were identified. First, there were variations in whether Primes stated they had worked, or intended to work in partnership with the NHS. This suggests that there might be low levels of collaboration and underdeveloped relationships in some CPAs. This was also seen in practice, and although some Work Programme provider organisations and local NHS services were attempting to seek ways to work together, there was clearly a need for more integration. However, the study took place during the early days of Work Programme delivery, when there were also NHS reforms, which were significant. In particular, some NHS and Work Programme provider organisations lacked a common understanding at both strategic and frontline service levels. Second, a lack of integration was shown to hinder Personal Advisers' practice, and level of support that could be made available for claimants, especially in relation to information sharing about claimants' health needs. This raises pertinent questions about how integration can be better achieved at all levels (both structural and individual) of Work Programme delivery. However, the 'black box' approach has increased the scope for idiosyncratic arrangements and appears to conflict with integration. In particular, as there are a large number of Work Programme provider organisations (Primes and subcontractors) operating within one geographical area navigation is likely to be time consuming. Exploration of how care for claimants can be integrated at a system level (to work out how the NHS services are commissioned), and what the required referral pathways and payment methods are, is clearly needed. In addition, effective partnership working, within the current NHS restructuring, is likely to require Work Programme provider organisations to be recognised as part of the health landscape, and to be integrated with other services.

One of the risks in Table 6.1 concerned the costs of employing healthcare professionals. Salary costs were identified as a concern to Work Programme provider organisations and in-house healthcare professional roles are likely to be less prominent than those in the previous PtW programme. This raises questions about whether these roles will work in practice, and whether claimants will have equitable access. In addition, questions are raised about whether Primes have sufficient clinical governance and management structures

in place for these roles factors which are likely to influence recruitment and retention.

Primes had varied approaches to subcontracting delivery of health-related provision. While some Primes paid upfront for a provision, such as CMP, and made this available for all of their supply chain, many of the specialist subcontractors were to be spot purchased. Typically claimants' access to these types of provision was at the discretion of their Personal Adviser, once a need had been identified. Therefore, the effectiveness of Primes' assessment processes is essential to prevent claimants' health-related needs being inadequately identified, or missed.

6.5.2 Effectiveness of Personal Advisers practice in addressing and assessing claimants' health-related needs

Personal Advisers were central to the Work Programme delivery across all Primes, and there was an expectation that they would be able to support claimants with health-related needs. However, there were inconsistencies in whether, and how, Primes would ensure their Personal Advisers were adequately skilled and trained to respond to claimants' health needs. Not all of the Primes proposed to offer specific health-related training, and some Personal Advisers were indicated to be more specialist trained than others. In practice, I found that when health-related support interventions could not be identified, or were not immediately available, some Personal Advisers felt powerless to know how best to support claimants, and there were indications that this could lead to 'parking practice'. This is of concern because only a minority of Primes made explicit reference to having in-house healthcare professionals to support Personal Advisers. Therefore, serious questions are raised about how Personal Advisers are practicing if they have not received adequate health training, and no healthcare professional support is available. Another risk identified in Table 6.1 was Personal Advisers' caseloads increasing, and less time being available to support claimants. It was notable that only one Prime indicated their expected caseload per Personal Adviser. In practice, it was evident that some Personal Advisers felt their caseloads were too high and that this did impact on their ability to support claimants. Thus, high caseloads appear to directly undermine the aspiration for a personalised service. Again this suggests that some claimants may not receive equitable levels of support, and may be

'parked' in the system. This raises questions about how Primes ensure that their Personal Advisers have manageable caseloads, and that claimants receive adequate levels of support when they have health-related issues.

6.5.3 Effectiveness of any health-related interventions in assessing and addressing claimants' health-related barriers to employment

While the effectiveness evidence base for the PtW CMP was found to be limited, the review in Chapter Three showed it was of value in helping many claimants improve their self reported health which can support their progress to work (Kellet et al. 2013). Although there was little explicit acknowledgment of the contribution that the PtW CMP made, types of condition management were commonly described. The new empirical research identified that two Work Programme provider organisations' CMP delivery was similar to the PtW NHS-led model. The bid review identified that a wide range of provider organisations were proposed to have a role in delivering health-related interventions. Some of these organisations were identified as utilising clinical and non clinical staff. While it was not possible to comment on the effectiveness of these interventions or competency of the provider organisations, it is likely that claimants will receive different levels of support. Therefore, questions emerge about the quality, adequacy and equity of services provided. Some Primes also identified a need to have healthcare professional input to assess claimants' functional capability for work. This is an area that is not being fully addressed by the WCA and it was not clear what other Primes were doing to solve this gap, or whether Personal Advisers were left to address this.

This bid analysis suggested that there may be a risk that some claimants could be purposefully excluded from a health-related provision if it was specifically targeted to meet local claimant health needs. In addition, further scrutiny of the bids' 'small print' raised uncertainty about whether all claimants might be eligible for specialist health assessments and CMP/health-related support, because Primes had additional eligibility descriptors (as shown in Table 6.7), such as 'severe' or 'serious'. These descriptors may be poorly defined and variably understood in practice. Therefore, it was not possible to judge the extent to which these types of eligibility descriptors could affect Personal Advisers' decisions about making health-related support available, or whether support would be rationed for those deemed to be in most need or closer to starting

work. Equally, it was unclear whether the effectiveness of a Primes' assessment and the way in which claimants may be categorised in relation to their health needs and/ or barriers may determine which claimants are offered health-related support. Conversely, there is a risk that demand will exceed supply, especially for those Primes who have documented that health-related support will be available for all claimants, and yet appeared to have made minimal provision. This was found in practice, as one CMP subcontractor had a waiting list. In this example, ensuring CMP interventions were kept within the agreed budget was a priority. Therefore, there is a risk that some claimants may not receive this provision if it needs to be rationed.

While some Primes' bids were clear about their intentions to support claimants to access NHS provision, there was minimal awareness that demand for these services might exceed supply. It was also uncommon for Primes to state that they would consider paying for additional services that might be needed. In practice, some claimants could wait up to six to seven months before they could access NHS services, for example, counselling. It was also apparent that some NHS stakeholders felt that Work Programme provider organisations should pay or contribute towards claimants' use of NHS services, particularly as the Work Programme payment model offers higher payments for people with complex health needs. Thus, there is a need for commissioners and providers (NHS and Work Programme) to negotiate agreements about these issues to ensure that claimants' needs are being met.

6.5.4 Effectiveness of claimants' engagement in pre and post work health-related support

A further assumption was that claimants would engage in the Work Programme. In practice, several Personal Advisers had concerns about claimants' health and used their 'enforcer' role to compel people to see their GP or attend a CMP. Interviews with two Work Programme healthcare professionals have provided new insights about how they were willing or would consider working with claimants who have been mandated. This shows that some claimants are being required to engage in work related activities, which has a health focus, which are likely to have been determined by a Personal Adviser rather than by shared decision making. This raises a number of questions about the benefits of health-related interventions that claimants have not volunteered to take part

in, and whether Personal Advisers are commonly enforcing such participation. It also raises a number of ethical and professional standards questions relating to healthcare professionals' practice.

6.6 Conclusion

This chapter has explored how the Work Programme policy intends to support claimants who have health-related barriers into work. It has shown that the Government has given Primes the flexibility to design their models. It has examined how Primes intended to support claimants within their delivery models. Some of these models appeared to have been influenced by Primes' evidence based practice and international evidence. The Personal Adviser role was found to be central to delivery, but there were variations in how this operates in practice. I have shown how Primes have indicated they will support claimants with health-related barriers and a wide range of health-related provider organisations, including the NHS, were indicated to have a role in the Work Programme. However, there were notable variations in health-related support provision in terms of size, content, delivery approach, eligibility criteria and the capacity to respond to demand. Thus, claimants with similar health conditions are likely to experience differential levels of service.

A number of key questions have been raised in this review, and some remain unanswered. In particular, it questions whether a state funded commissioned intervention can stimulate innovation and provide evidence of 'what works'. This is crucial because there is an underlying assumption that the 'black box' and market based approach will enable organisations to innovate and deliver the required results. It also raises concerns about whether Primes that do succeed in helping claimants into work will be willing to share their evidence, or whether this will remain a contractual secret. These issues will be further explored in Chapter Eight and Nine. The next Chapter concerns Personal Advisers and explores their micro-level interactions with claimants who have health conditions by focusing on how they assess and address health-related needs within the Government's current employment support provision.

Chapter Seven: A micro-level exploration of the Personal Advisers' practice context: interacting with Work Programme and Work Choice claimants who have health conditions

7.1 Introduction

The overall focus of this chapter concerns the micro-level interactions between a Personal Adviser and a claimant. The chapter presents the findings from the fieldwork observations which took place across three different organisations (two Work Programme providers and one Work Choice provider) and involved 29 in-depth interviews with Personal Advisers, claimants, programme managers and Work Programme Condition Management Programme (CMP) healthcare professionals. This chapter explores how Personal Advisers' different role dimensions are played out in their everyday practice, and questions how salient the demands of dealing with claimants' health issues might be. The ways in which claimants responded to Personal Advisers during their interactions, and their views and experiences of the support they received are examined. This investigation helps to ascertain whether Personal Advisers are prepared and equipped to support claimants with health conditions, and considers the factors that can help or hinder their practice.

The findings are presented in four sections. A prologue is provided at the start of this section. The first section (7.2) begins by identifying the role of the Personal Adviser and the key health-related practice tasks that they needed to perform when working with claimants who have health conditions. The second section (7.3) shows Personal Advisers' and claimants' behaviour patterns, styles and strategies that they adopted during their interactions. The third section (7.4) describes how Personal Advisers perceived and valued the health aspects of their role, and explores the factors that affected their practice. (7.5)

describes claimants' view of Personal Advisers. The chapter concludes with a summary of the key findings.

The methods employed to capture and analyse this data have been detailed in section 4.4.3 in Chapter Four. Details of the context of the fieldwork observations are shown in Figure 7.1. The aim of the analysis was to explore Personal Advisers' micro-level interactions with claimants who had health conditions in order to address the following research questions:

Micro-level

- 6 What strategies do claimants with long-term illness adopt in order to manage their health whilst they participate within welfare-to-work provision?
8. What strategies do Personal Advisers adopt within their practice involving claimants with health-related needs?
9. What competencies does a Personal Adviser need to support their ways of working with claimants with health-related needs?

It also addresses:

Meso-level

4. What types of health-related support do claimants' access from their Personal Adviser?

Figure 7.1 Example contexts of the one-to-one Personal Adviser and claimant interactions that were observed

Q

pe Adv
Cm

The prologue presented in Box 7.1 is taken from an observation of an initial assessment between Sue, a Personal Adviser and John, a claimant who was attending a new employment programme for the first time. It provides a contextual backdrop for the rest of the chapter.

Box 7.1 John's initial assessment with Sue¹⁴

John was in his early forties and was looking for part-time work. He had not worked for about 18 months and was attending the programme voluntarily. John had switched benefit type three times since his first claim for benefits and received Employment Support Allowance (ESA). He had a Disability Employment Adviser (DEA) at Jobcentre Plus (JCP). John also had caring responsibilities and was in the process of divorce.

John was dressed casually in jeans and arrived about thirty minutes late for his appointment. His assessment took place in a large group room with an open plan doorway which led into a main corridor with adjoining group work rooms. There was a long row of desks with computer desktops against a wall down one side of the room. At the end of the room, furthest away from the doorway, Sue had taken a seat at her desk which housed her computer. She had an open notebook and pen on the desk. John walked unaided while he carried a hot drink to a chair at the side of Sue's desk so that he was facing both Sue and the window. He held his hot drink in his lap during the assessment. Sue alternated her position throughout the session switching between facing John to facing her computer screen, where she inputted data and made notes while he talked about his health conditions. Sue started the assessment by stating that she was "an adviser" and then asked John what he knew about the programme. She told John that she would give him a copy of the programme outline later as she had not found one on the shelf near her desk. Sue went on to explain that the

¹⁴All of the names given in this chapter are pseudonyms to ensure participants' confidentiality.

organisation could help with CV's, work placements, qualifications, confidence, referrals for condition management and debt support.

John then stated that he had already had "CMP", but had withdrawn because of ill health. *"My health is deteriorating rapidly (...) I'm not sure if I will have mobility within the next five years"*. He then talked about how he had *"a severe lack of oxygen in my blood"*. Sue said that she was going to ask lots of questions and write some things down. She then looked at her screen. John continued to talk about his longer term health problems and the reasons why he had previously been unable to work for many years. He mentioned that his liver function tests had been abnormal and that he could not walk and needed to have rehabilitation. Sue asked whether John received any diagnosis about his condition. John replied no *"they didn't"*. Sue brought the topic of conversation back to present events and asked John about his recent health conditions. John proceeded to talk about his glandular problems which related to several incidents that occurred a few years before. These problems resulted in difficulties with eating and drinking. John went on to describe an upsetting event that had happened during an operation and mentioned how he went into intensive care.

Sue asked John if these health problems have now *"resolved"*. John told her they had, but then started to reveal how he had ongoing problems with his jaw which *"left me with decreased feeling in my left side of my face"*. He continued to describe how he had *"frequent chest infections, 18 in the last 24 months. (...) I am on constant antibiotics for the chest infections"*. Sue was sat facing the screen and typed a record of John's account. She made no eye contact, no head nod or any sound at this point. John continued and started to expand more graphically. *"Then I went into ICU, I was fighting for me life"*.

Sue replied *"yes yes"*, and continued typing as John continued to talk about his health. John then bent forward and started to roll up the left leg of his jeans in an

attempt to show Sue the problems he was having with this leg. Sue did not look towards his leg, but asked John if he knew what seemed to be causing the swelling. She asked if his condition had a name. John did not know what his conditions were called, but he continued to talk about his medications and how long he had been taking these. He then told Sue that he was having investigations after she inquired about any ongoing treatments.

Sue then told John that she just wanted to check that she had all of his conditions documented and read out aloud what she had written. While she was recounting John's details about his glands, he interrupted and stated "*the other one has started*". Sue sought clarification. "*Will you be having that reviewed? How do they manage that?*" John moved on to talk more about his medication. "*I'm on about 40 a day*". John started to list the names of these. There were six different ones. He went on to talk about needing another liver biopsy later in the year. Sue asked how this affected him. John talked about how he got tired and had muscle fatigue syndrome and that by eight o'clock, his eyes were like "*matchsticks, I'm that tired (...) that's when I struggle to keep awake*". Sue asked about his mobility, and whether he had been given any advice on managing this. John told her that he cannot bend his legs properly.

Sue then checked about any further advice John had been given for his condition. John told her that he had been told to "*take one day at a time*" and that "*one day you might not be able to get out of bed or anything*". He then went on to tell Sue that "*my hands are also starting to go as well now. (Name of his JCP DEA) gave me a DLA form. She advised me I should be signed off 'you're not fit enough to be employed at the moment'. But see it's not good sitting staring at four walls 24 hours a day*". Sue then asked John if there was anything else from a medical point of view that he would like to mention before they moved on to the next part of the assessment. John did not add anything further in relation to his health conditions.

7.2 The role of the Personal Adviser: key health-related practice tasks

In this section findings are presented to illustrate how different Personal Adviser role dimensions were observed to play out in their day to day practice. The eight Personal Adviser role dimensions that were derived from the synthesis of earlier research findings in Chapter Five are outlined in Table 7.1. Two new role dimensions - health promoter and health monitor - were identified from the fieldwork observations, and these are introduced and described below.

The practice-level data confirmed that Personal Advisers' practice involved a broad range of tasks that could be carried out at different stages of a programme's delivery. Some of these tasks were unrelated to claimants' health issues. Therefore, to help organise the presentation of the data, an exploration of Personal Advisers' practice in relation to claimants' health during their start on a programme, and any pre work or post work support that was offered was conducted. Assessing and addressing claimants' health-related barriers to employment were two key health-related practice tasks that Personal Advisers performed. The related activities that Personal Advisers performed - as revealed by both direct observations and interview reports - are described in sections 7.2.1 and 7.2.2 and are outlined in Table 7.2.

Table 7.1 Ten Personal Adviser Role Dimensions

Personal Adviser role dimension	Statement of role dimension in relation to health
1. Assessor	Identifying claimants' health problems and related barriers to employment.
2. Counsellor	Listening to claimants' accounts of their health condition, and being empathetic.
3. Gatekeeper	Making decisions about which health-related interventions might be beneficial for claimants.
4. Enforcer	Identifying if a claimant has a 'good' reason for non programme attendance and/ or engagement which relates to their health condition.
5. Enabler	Identifying appropriate work related activities that do not compromise claimants' health conditions.
6. Navigator	Identifying additional support options for claimants' non health-related problems which might impact on their health.
7. Seller	Liaison with employers to inform/educate about a claimant's health circumstances, and promoting types of jobs to claimants.
8. Advocate	Supporting claimants' illness perspective and reinforcing a 'not fit for work' message.
9. Health Promoter	Providing health-related advice to promote claimants overall health in addition to the selling of, health-related benefits of working.
10. Health Monitor	Observing and questioning claimants about their general health.

NOTE: Role dimensions: 1-8 were derived from the synthesis of earlier research findings (prior to the Work Programme) in Chapter Five and confirmed during the new practice-level data collection involving the Work Programme and Work Choice.

9-10 were identified from the new empirical data which is presented in this chapter.

Table 7.2 Key health-related practice tasks performed by Personal Advisers

Programme start	Completing a formal assessment process.
(Assessing)	Gathering claimants' health-related information.
	Getting to know a claimant.
	Building rapport and trust.
	Interpreting claimants' health-related information.
	Identifying claimants' health-related barriers to employment.
Pre work support	Identifying and recommending health-related support interventions.
(Ongoing assessment and addressing)	Ongoing assessment in 1-1 and group activities.
	Liaison with other professionals.
	Action planning activities: agreeing and setting goals.
	Identifying job goals and suitable types of employment.
	Personally providing health-related.
	Providing assistance with job search and job applications.
	Providing assistance with interview preparation.
Post work support	Identifying any in-work support needs e.g. reasonable adjustments.
(Ongoing assessment and addressing)	Monitoring and addressing any further or new in-work support needs.

7.2.1 Assessment of claimants' health-related barriers to employment

"... some [claimants] view us as like a medical, so they have to give us everything, you know, justify the fact that they're ill, and then others will be very shy about it, and there might be things that we don't find out until we're working with them that are actually really important in terms of their adjustments and what support and what type of jobs they can do..."

(Personal Adviser- in-depth interview).

The formalised assessment procedures varied across the three organisations in which fieldwork was conducted, for example, in the level of privacy in one-to-one interviews, as shown in Figure 7.1. Two of the provider organisations used an IT led assessment. In contrast, the third provider organisation adopted a paper led assessment which was inputted into a computer system at a later stage. In-house healthcare professional led assessments were also available at one of the provider organisations.

Prior knowledge

Some Personal Advisers received health-related information about a claimant prior to meeting them for the first time. For example, details could be made available in referral documentation from JCP, and some Personal Advisers were observed to read this before meeting with a claimant. Additionally, some Personal Advisers communicated with a claimant, usually by phone, before they met. These conversations could alert a Personal Adviser to a claimant's health-related problems. Although helpful details about a claimant's health condition could be made available prior to a formal assessment, it was not uncommon for Personal Advisers to remark on the limited use, or uselessness, of documentation that they received from external sources such as DWP, or a previous provider organisation. As such, this information could be described as out of date or inaccurate.

"...I never look at previous provider information because it's usually useless."

(Personal Adviser).

"... and basically on the action plan it was 'customer was really bad with mental health, stress and everything', and when I spoke to the customer they were like I didn't, I didn't see it was that bad, and I've shown them what it said and they were like no (...) so yeah, the information that we do get isn't always true neither, so it's kind of hit and miss".

(Personal Adviser).

Therefore, Personal Advisers often relied on their own skills and ability to encourage claimants to disclose any health-related barriers, and to pick up on any observable behaviour that may indicate a health-related problem.

"I think the quality of information depends on the adviser and how they are able to question the individual, how they're able to see maybe body

language and if there's something maybe hidden to just maybe go around it."

(Personal Adviser).

Assessment approaches

Fieldwork observations showed that there were different ways in which Personal Advisers enquired about claimants' health and responded to their answers. For example, the prologue of John's assessment highlighted the high level of detail that a claimant might disclose during an assessment. The extent of further questioning that a Personal Adviser might engage in was also shown by Sue's probing for further information. In contrast, some Personal Advisers were observed not to probe for health-related information. In addition, claimants could also choose to withhold information about their health. For example, when asked by his Personal Adviser whether he had a physical or mental health condition, one claimant answered 'no' to both questions. This Personal Adviser did not ask any more health-related questions during this session. However, in conversation with me this claimant revealed he had anxiety problems and depression for many years. I observed several follow up appointments between this claimant and his Personal Adviser, and his health conditions were never mentioned. However, there were comments made by this claimant, during his appointment, which could have prompted his Personal Adviser to ask about his mental health. For example, this claimant mentioned that he was looking for full-time work with 9-5 office hours but that he preferred afternoon programme appointments, because he struggled to get up in the mornings. These difficulties could be associated with his depression. It is not known if the Personal Adviser noted the remarks made by this claimant and suspected that he might have a mental health condition and chose to ignore it. Alternatively, the Personal Adviser may have been waiting for the claimant to talk about any health problems at a later stage (which was a strategy employed by some Personal Advisers as shown below), or the Personal Adviser may not have made a connection between the claimant's difficulties and a possible mental health condition. Equally, whether this claimant felt able to manage his condition is difficult to confirm. Nevertheless, this case illustrates the way in which health-related issues can remain outside of the Personal Adviser and claimant interaction, despite their potential relevance to securing employment. Moreover, the findings presented so far have not considered Personal Advisers'

and claimants' views about whether they perceived the Personal Adviser as having a legitimate role in supporting their health, and whether and how these views might have influenced their interactions. This is considered in section three.

Most of the Personal Advisers highlighted the importance of getting to know claimants, and talked about how their assessments could evolve over time.

"...step one is just to show an interest, step two is to win his confidence, step three is for him to talk to me, not for me to be asking and quizzing him, but for him to be talking to me and freely engaging in conversation, and after about six or seven times of meeting we started to talk about his diabetes..."

(Personal Adviser).

Hence, Personal Advisers might need to adopt an assessor role at different stages of a claimant's programme participation which may not be confined to a formal assessment process. For example, during fieldwork observations claimants disclosed information about their health in open environments such as waiting areas, or group activities which included programme introductions.

"I mean some people, as you will know as well as me, open up almost before they've come into the room, in fact everybody gets it, I had one at the welcome session this morning..."

(Personal Adviser).

One young male claimant was observed telling the provider organisation's receptionist that he had just been on a hospital ward for two weeks for his depression before entering the job club.

(Fieldwork notes- observation).

These examples also reveal the way in which claimants' health conditions may fluctuate during their period of engagement with a provider organisation. This highlights the importance for Personal Advisers, and their extended team to be vigilant in their day to day practice to be able to pick up, and respond to, the different ways in which claimants might display or talk about their health. For instance, in the example above it was not known if the receptionist informed the claimant's Personal Adviser about his recent hospital admission for depression, and whether this gentleman may have benefited from additional support during

his attendance that day. However, when I observed this claimant in the job club he appeared to struggle to focus on his job search activities. He also asked me for help on several occasions.

Other assessment tasks that Personal Advisers needed to perform were to make sense of claimants' health-related information, and to identify factors that could affect their employability. One of the challenges that some Personal Advisers expressed in relation to this task was their uncertainty about the accuracy of a claimants' own health-related account. This was especially problematic with regard to determining the impact of a claimant's health condition and ability to work when they received Jobseeker's Allowance (JSA), and had a requirement to seek full-time work. This task appeared to link to Personal Advisers' awareness of their responsibility as an 'enforcer'.

"One particular young lady I see, who strikes me as being quite fit, and as we progressed into, you know, seeing her more and more, she first told me her main priority was looking for bar work, then retail and then cleaning. Obviously condition of receiving your Jobseeker's Allowance is that you're willing to do full-time work, as the weeks went by she were only looking for stuff under 16 hours, (...) So when she came in I sort of brought her in and had a chat with her, and she came up with I've got a curvature of my spine and I can't work, I can't do more than 16 hours in a bar, it's too much. I said well why are you looking for bar work then if you know you can't do it full-time, there were a whole range of excuses, but I think she may have a degree of curvature to her spine, but nothing severe enough to, to sort of make her bedridden for days like she claims..."

(Personal Adviser).

Digging deeper

Asking claimants about their medical diagnosis was one way in which Personal Advisers attempted to find out more health information. An example of this was shown in John's case earlier. However, Personal Advisers sometimes struggled to cross reference claimants' health-related information, especially if they were not provided with a medical diagnosis. Therefore, they would employ a range of strategies to find out more about an individual's account of their health condition. These strategies included asking health-related questions if there was a JCP "Person with Disability marker" on their referral details, and encouraging claimants to take part in group work. Group work was used to

support further assessment by observation which sometimes involved a Personal Adviser's colleagues. Taking the time to get to know an individual was considered useful, particularly if claimants could be seen on a different day or at a different time. These additional assessments helped Personal Advisers to determine a claimant's abilities, and to ascertain the impact of their health condition on daily activities.

Some Personal Advisers tried to find out more information by consulting with healthcare professionals who were already involved with a claimant. In one organisation I was able to observe Personal Advisers talking about claimants' behaviours in their team meetings. Through peer discussions, Personal Advisers sought to find explanations for claimants' health-related behaviour and how they could respond to any challenging situations. For example, in one meeting a Personal Adviser recommended that her colleague contact a claimant's Occupational Therapist to help explain why he was behaving inappropriately whilst attending their programme. Seeking information from a claimant's GP, or asking claimants about any work related advice they had received from a healthcare professional was another strategy observed. However, these strategies did not always appear to be helpful in terms of increasing a Personal Adviser's level of confidence and certainty. For instance, it was not unusual for claimants to report that their GP offered little or no work related advice as shown in this extract from an observed assessment where a Personal Adviser asked a claimant:

"Is work something you've talked about with your GP and psychiatrist?"

The claimant replied: *"I told them a few months ago I would like to but they haven't said anything."*

(Fieldwork notes- observation).

"I actually asked my doctor, and he, I said about work wise, and he, and it was actually him that said well you'll be alright (name of participant) as long as you're not sat for too long at a time, or you're not stood up for too long at a time, so like I say that's the only conversation I've had with the doctor and he says well if you can find a job where you're, fits that bill, he says not too bad"

(Claimant).

Additionally, some Personal Advisers found it could be a struggle or impossible, to liaise with claimants' GPs or other healthcare professionals.

"I have got one customer whose mental health worker comes with her, but that's only because she can't leave the house, but he sits there and he doesn't speak about, he doesn't have any impact on the interview at all, so we tend to not, nobody contacts us, and then the other side, if we tried to contact them they won't speak to us, data protection, it's very hard, we're like in a box on our own that nobody wants to talk to us "

(Personal Adviser).

"We won't get any feedback from a GP"

(Personal Adviser).

Other factors that Personal Advisers found problematic in their assessments included situations where they suspected a claimant might have an undiagnosed health condition and not be seeking medical support, or reported to have a health condition through self-diagnosis. These situations could be worrying for some Personal Advisers, particularly if they thought a claimant's health condition was serious. Strategies that were employed to deal with these situations were identified to be similar to those described above in attempting to gain more information and clarity. In addition, the signposting of claimants to a GP for further investigations was a common recommendation made by Personal Advisers. In a minority of cases, Personal Advisers in one programme extended their enforcer role dimension and used their mandatory 'powers' with the threat of sanctions as a way to coerce claimants to see their GP.

"...we've been talking to advisers generally about health problems, and they've had customers who've been so ill that they've mandated them to go and see their GP, and they've had serious illnesses as well, like cancer and stuff, and they've mandated them, saying if you don't go and see your GP I'm going to sanction your benefits, because they can see that they're so ill".

(Healthcare Professional Condition Management Programme).

Personal judgement, skills and experience

In contrast to focusing on health, some Personal Advisers explained how they decided not to dwell on this issue, for example, if a claimant indicated that their condition was not a problem, in relation to seeking work. Hence, some

Personal Advisers talked about the importance of shifting from a health focus (once claimants had talked openly about their health condition), to a work focus and supporting claimants with work related activities such as CV preparations. An example of this was observed in John's case in the prologue. These different practice approaches illustrate the extent to which a Personal Adviser's personal judgement, skills and experience might influence their practice and the level of discretion and autonomy they have in deciding how much attention they give to claimants' health issues. During fieldwork observations, one programme manager spoke about a team problem where Personal Advisers' action plans lacked a health focus. Consequently, this organisation implemented positive changes to improve the health focus in action planning activities. These improvements had been acknowledged and recognised at a national level within the organisation which suggests this was unusual.

Supporting claimants' illness or wellness perspectives

Another health-related assessment task that was required occurred when claimants sought advice from their Personal Adviser after their WCA. Fieldwork observations suggested that Personal Advisers' assessment decisions during these interactions could be challenging, particularly as claimants' health conditions could fluctuate following their WCA. Some Personal Advisers appeared to have been influenced by their own perception about the nature of an individual's health condition, and whether they perceived a claimant as 'fit for work' or not. Whilst accepting that a Personal Adviser needed to exercise their judgement during these interactions, there were no examples observed to suggest that a standardised approach or organisational process was followed to support their actions. Therefore, there were inconsistent approaches observed when Personal Advisers completed this task. Furthermore, a Personal Adviser's choice of action in this task was not necessarily known or expected by their manager.

"... we're not an advisory in that respect, you know, we can't advi... we advise but, or we can signpost, but at the end of the day it's down to the medical assessment, I mean we know, well it is what it is, what they say goes, we can't, you know, defend the customer to say that's not right, because it's not down to us to do that."

(Manager).

Moreover, I observed some Personal Advisers' actions that took place in the absence of being fully informed or trained about an individual's health condition. Thus, Personal Advisers could make judgements, and practice decisions that may not necessarily be in the best interest of a claimant.

I also observed some interactions where Personal Advisers agreed with a claimant's view about being unfit to work as shown in Box 7.2. Support was also provided for a claimant's appeal process. Consequently, a Personal Adviser's practice response to claimants in these types of interactions has the potential to influence or reinforce either an illness or wellness perspective. Examples to illustrate this were particularly evident in two fieldwork observations that involved two claimants who sought support and guidance from the same Personal Adviser. Both claimants were already known to their Personal Adviser. Both claimants experienced anxiety and depression and were appealing their 'fit for work', WCA outcome decision. One claimant named Paul, perceived that he had "*failed*" his WCA, and the other claimant named Bob, felt he would not "*pass*" his WCA appeal. These interactions are described in two vignettes in Boxes 7.2 and 7.3.

Box 7.2 Bob's interaction with Jill

Bob's session started as he showed Jill a letter he had received from the Department for Work and Pensions about not being entitled to Employment Support Allowance (ESA). He also handed over a copy of his Work Capability Assessment (WCA) decision letter. Bob then put a copy of his hand written notes, which were used to fill in the original paperwork for his WCA, onto the table. During the session, Bob leant forward placing his elbows on the desk and the palms of his hands on his cheeks. He was quiet at times and nodded his head when Jill spoke and only occasionally said "yes".

Jill led the session, and read through the documents that Bob had provided. While she was reading his WCA report she started to argue each point out loud. Using her pen Jill highlighted the document which stated the reasons why Bob had not been awarded ESA. Bob told Jill that his WCA was three months ago, but his letter had only just arrived and his benefit stopped a few weeks ago. Bob went on to tell Jill that his medical assessment only lasted for 45 minutes and that he got zero points. Jill told him he needed to appeal within a month.

Jill asked Bob if he told the medical adviser about his cognitive behavioural therapy treatment. Bob told her he had mentioned it. Jill said there was nothing about this on Bob's report. She tapped her pen on the desk. Jill then went through the physical functions sections on his form and to where it mentioned his memory. Jill talked about Bob's difficulties such as leaving the cooker on. She also talked about how they had filled in his original assessment paper work together. They both disagreed with the WCA report and the safety aspects that were documented. Bob told Jill that the details that he had provided should have been *"port of the assessment"*, but stated it did not look like they had been included. Jill said they *"obviously they ignored it"*. She then told Bob that he had provided a very detailed account on his original assessment documentation.

Bob explained how this terrible news had *"put me bock several months"*. Jill wrote on his report, and highlighted things that Bob could say in his appeal. Bob listened and leant forward while Jill spoke. Jill then talked about Bob going to the doctors to get a sick certificate. He told her this could be a struggle and that he *"can't get o doctor's note"*, *"I can't see him"*. Jill told Bob how she managed to get an appointment with her GP for a prescription, and advised him about what he could do. She then told Bob that she could see him shaking while he sat at her desk. Bob said *"I wasn't aware of it"*. Jill mimicked Bob's symptoms with her hands so that he could see what he looked like. Jill then told Bob what he needed to do when he got home and how he should proceed to write his appeal. She suggested that he did this on his computer, and that she would *"check it" for him*. Bob then went on to talk about having no money and *"relying on an overdraft"*.

Jill explained the importance of getting his appeal completed quickly. Jill continued to go through Bob's assessment and marked areas with a green highlighter pen. In relation to Bob's health problems, that Jill felt had not been taken into account, she told Bob that *"it really really angers me when they ignore it"*.

Bob then told Jill that he had started cycling again, and Jill talked about her walking activities and how these had helped her depression and stress. Bob agreed to what Jill suggested about his appeal. As Bob left, Jill reminded him that he could send her a copy of his appeal by email, and that she was willing to check this through for him. _____

Box 7.3 Paul's interaction with Jill

Paul arrived to his appointment in casual dress and was unshaven. During the early part of his session, he frequently rubbed his hands together. When he first started to talk to Jill, he explained that he was worried about his forthcoming Work Capability Assessment (WCA) appeal. Jill offered reassurance. She explained that her ways of working would not change if Paul no longer received Employment Support Allowance and he had to switch to Jobseeker's Allowance following his appeal. She stressed that she did not want him to worry about this.

Paul shared his fears about being made to look for work, and accept a job which could make him unwell. This had happened before when he was attending another programme. Consequently, he received sanctions to his benefits and became unwell. Jill acknowledged this and told Paul that he looked tired. He then told her he had not been sleeping.

Jill began to change the topic of conversation and gave Paul positive feedback about his recent participation in a voluntary work placement. Paul told Jill that was good to hear, and mentioned that he would like to work there if a job ever became available. Paul went on to ask lots of questions about jobs and courses that he would like to do in the future. Paul continued to talk and informed Jill about his current courses.

Jill encouraged Paul to think about apprenticeship schemes, and he questioned whether he would be too old. Jill sought guidance from a colleague who had information about such schemes that might interest Paul. Paul listened to this conversation and then agreed to look into this further.

Towards the end of the session Paul agreed work related activities and actions that he would complete before his next session with Jill. Before the session ended Paul engaged in informal conversation with Jill and her colleague. Paul appeared cheerful and was smiling while he discussed his hobbies with the two Personal Advisers. His hobbies were also related to his work interests. There was no further mention of his WCA or forthcoming appeal before Paul said goodbye.

As shown in Box 7.2, in her interaction with Bob, Jill appeared to adopt an advocate role by focusing on his appeal throughout the whole session. Jill appeared to reinforce an illness perspective by repeatedly telling Bob that he was unwell, and making comments about what he could not do. She stressed how visible his symptoms of anxiety were during their interaction. Jill also demonstrated her disagreement about Bob's WCA decision outcome by tapping her pen on the desk and sighing. She also questioned the decision maker's comments, and marked Bob's WCA assessment documentation with crosses and scribbles over the points she believed were wrong.

In contrast in Paul's session, as shown in Box 7.3, Jill appeared to adopt more of an enabler role, and gradually moved away from his concerns about not 'passing' his appeal. Jill then directed the conversation towards Paul's future

work aspirations and goals. Here, Jill appeared to adopt a wellness perspective while reassuring Paul that she would continue to support him. She explained that he would still be able to take his time and prepare for work that was suitable. In addition, she explained how she would make sure that his health was not compromised by his programme attendance or her involvement. This example also highlights the extent to which Jill felt she had power over her enforcer role dimension by making it clear that she would not exercise this if Paul switched benefit.

In summary, the task of assessing claimants' health-related barriers appeared to serve three main aims for a Personal Adviser: i) to meet the requirements of the organisation's assessment process and action planning activities. Primes (Work Programme) were also noted to request details about claimants' health conditions for audit purposes, ii) To enable the Personal Adviser to determine whether, and how a claimants' health condition may be a barrier to employment, iii) To enable the Personal Adviser to adopt different role dimensions, particularly the enabler role and discuss appropriate support interventions which might address claimants' health-related barriers to employment.

7.2.2 Addressing claimants' health-related barriers to employment

This section describes how Personal Advisers helped claimants to overcome their health-related barriers to employment. A wide range of employment barriers were expressed by claimants and these have been categorised in relation to: a health condition; the local labour market; employers; employability; and life events, and are presented in Table 7.3. It is necessary to note that although these are listed as separate barriers, it was rare for claimants to experience only one. Three ways in which Personal Advisers might approach addressing claimants' health-related barriers are now described in turn.

Table 7.3 Employment barriers expressed by claimants

Claimants' barriers to employment	Pre work
Health-related condition factors	<p>Being unsure about the types of jobs that would be suitable.</p> <p>Being unsure about managing functional restrictions and limitations such as pain in a work environment.</p> <p>Being unable to drive due to the impact of a health condition.</p> <p>Fear of travelling on local transport (e.g. due to experiencing panic attacks).</p> <p>Fear of being unable to sustain work once in employment.</p> <p>Being unable to engage or maintain engagement in job search activities due to anxiety, depression, lack of motivation and stamina to complete tasks such as application forms.</p> <p>Being unable to leave the house without support due to anxiety.</p> <p>Being unable to stand or sit for long periods of time.</p> <p>Being unable to engage in heavy lifting or physical tasks that are required for previous job roles.</p> <p>Awaiting further medical investigations.</p> <p>Feeling suicidal.</p>
Local labour market condition factors	<p>Believing that there were no jobs available.</p> <p>Only wanting part-time work.</p> <p>Not wanting temporary work due to the financial risks of leaving benefits.</p> <p>Wanting to work near home.</p> <p>Not wanting to work in a low skilled job near home for fear of being recognised by people within the local community.</p>
Employer factors	<p>Feeling concerned about a past work history and worrying about getting a poor reference from a previous employer.</p> <p>Change and off manner when communicating with prospective employers once they learn about a claimant's health conditions could be off putting.</p> <p>Worrying that a prospective employer will think they have been out of work too long.</p> <p>Being concerned that having a health condition would be held against them.</p> <p>Being unsure about their identity and whether they are classed as disabled or not.</p> <p>Feeling unsure how to broach the topic of their health at job interviews.</p>
Employability-skills factors	<p>Wanting to be retrained because their past worker role was no longer possible, and could compromise their health.</p>
Claimants' barriers to employment	Pre work
Other factors	<p>Fear of leaving benefits and being financially worse off.</p> <p>Unable or struggling to support the costs of job search: not having access to the internet, having to pay for mobile phone and travel.</p> <p>Struggling to use a computer for job search activities.</p> <p>Having no confidence.</p> <p>Waiting a year before employability support is offered.</p> <p>Behaviour or demands of others impacts on ability to engage in job search activities e.g. family issues and caring responsibilities.</p> <p>Dealing with relationship problems e.g. divorce.</p> <p>Feeling angry and upset at Jobcentre Plus and the sanctions regime.</p>

Feeling anxious and engaging in an appeal process for sanctions that have been imposed by Jobcentre Plus.

Feeling anxious and upset in an appeal process regarding the outcome of their Work Capability Assessment.

Feeling anxious, angry and upset about their limited financial resources to support the basic costs of living e.g. to buy food.

NOTE: Barriers shared in interactions with Personal Advisers, informal conversations during observations and research interviews.

Recommending professional healthcare led support either in-house or externally

Personal Advisers' use of healthcare professional led support was found to vary. For instance, where CMPs or in-house healthcare professionals were available, in one organisation, some Personal Advisers valued this resource, and talked about its benefits, while one Personal Adviser had not made any referrals and reported to have limited understanding of what CMP could offer. One in-house healthcare professional in the same organisation explained that time constraints had prevented their CMP training going ahead. In addition, one CMP practitioner in another organisation felt that some Personal Advisers did not discern which claimants might benefit from CMP as some made regular referrals while others made none. This data highlighted how Personal Advisers might be challenged when they adopted a gatekeeper role. It also illustrated that some Personal Advisers might be inadequately prepared to decide who should be given access to this support. Thus, some claimants may be inappropriately excluded from accessing available health-related support interventions, particularly if Personal Advisers do not have clear organisational processes to guide their decisions.

Some Personal Advisers talked about the benefits of the previous Pathways to Work CMP, and one mentioned she missed this option. Another Personal Adviser explained that she would try to access a CMP via a claimant's GP, but was not sure if this would be possible. Therefore, in the absence of in-house CMP there was a need for Personal Advisers to be resourceful and knowledgeable about other health-related provision that might be available. Signposting and encouraging claimants to see their GP was the most common strategy that was employed across all three of the provider organisations that were observed. Some Personal Advisers also recommended or supported

claimants to seek referrals to NHS cognitive behavioural therapy type interventions, for example, Improving Access to Psychological Therapy services.

Seeking external third sector health-related support services

Personal Advisers often signposted claimants to health-related support provision which was available from provider organisations in the third sector, for example, Mind. The use of signposting could also be associated with Personal Advisers' frustrations about the NHS waiting lists for interventions such as counselling. Personal Advisers choice of external organisations more typically involved those that they had previous experience of, or as already mentioned, were identified through internet searches. However, adopting the role of the navigator to search the health landscape for services (including NHS-led) could be challenging, especially in knowing who was who, and who did what. One manager was observed to help her team develop networks with local health-related support services. However, in general the onus to seek out support services was left with the Personal Adviser. This task was sometimes observed to take place via a web based search during a claimant's appointment. One Personal Adviser was unfamiliar with the local area and which services were available and the internet was helpful in this case. When new support services were found to be useful, some Personal Advisers were noted to share these with their colleagues. I did not observe any use of a systematic system in relation to this.

Personally providing health-related support interventions

Interventions that were provided by Personal Advisers involved one-to-one or group type interactions. One-to-one interventions involved discussions and advice about claimants' barriers and problem solving activities. Attempting to change claimants' "*mindset*" regarding their health-related barriers to employment was a key practice task that many Personal Advisers talked about.

..he had the condition I've got, arthritis, and you know, sciatica going on, but it's stopped him from completely working for years, and he spent years and years on sickness benefit, and then in his own words ATOS cured him, without telling him, after he went for the medical, they obviously said well actually he probably could go to work if he tried, so he's got a real bee in his bonnet about it and it's very difficult to get him, oh I can't do that because of my back, I probably wouldn't be able to do this, and slowly, you know, obviously talking about my experiences as well with him, I'm getting him to see that possibly he could do something

else and if he just adjusted the way he worked to, you know, work around his pain management."

(Personal Adviser).

Therefore, Personal Advisers mentioned that by focusing on what claimants could do and highlighting the benefits of work, they would try to help claimants overcome their health-related barriers to working. The emphasis here was on the health benefits of working, such as increased social interaction. This type of intervention could be characterised as part of a new role dimension "health promoter" (see below).

Other barriers that Personal Advisers were observed to try to address included: i) identifying types of work that would be suitable, ii) addressing claimants' dilemmas about disclosing their illness on their CV or during a job interview which might involve discussion about their identity and whether they perceived themselves to be disabled or not, iii) approaching employers on the claimant's behalf to discuss claimants' health problems prior to their job interview, starting a work placement or work iv) Identifying or suggesting reasonable workplace adjustments. This involved finding ways in which claimants might be able to manage their health condition within a new work environment. This included referring claimants to services such as Access to Work which provides in-work support services.

In summary, the findings indicated that Personal Advisers adopted many different approaches to helping claimants address their health-related barriers. Some of these barriers were perceived to need professional healthcare led support or external third sector support, whilst others were seen as appropriate for Personal Advisers to address. The latter category included barriers that were perceived to be related to claimants' beliefs or 'mindset' i.e. more perceptual in nature. Thus, personally addressing certain health-related barriers was viewed by most Personal Advisers as a legitimate task to perform in their day to day practice.

Additional role dimensions

Fieldwork observation of an in-house Personal Adviser led course and a documentary review of another course revealed a Personal Adviser role dimension "health promoter" – that was not documented in the review of earlier

research findings (Chapter 5). This role involved giving health promotional advice to claimants about their general health. Examples of the topics that could be covered included: the importance of having a good sleep pattern, healthy diets, problems with energy drinks, benefits of complying with medical treatments such as physiotherapy and taking prescribed medications regularly. These types of topics were also briefly discussed, though not frequently in one-to-one sessions. For example, a claimant was given a booklet about her health condition which covered self-management, and information about an online cognitive behavioural therapy course.

There were a few occasions where Personal Advisers exceeded their role boundary. Examples included, two Personal Advisers who suggested claimants try certain medications to manage their health condition better. There were also a few examples where Personal Advisers' health-related advice could (in my opinion) conflict with a claimants' existing NHS treatment, but it was not possible to explore this in more detail.

A second new role dimension - "health monitor" - also emerged during fieldwork observations and was suggested in the material generated in some of the interviews with Personal Advisers. This role appeared to be closely associated with Personal Advisers' tasks of assessing and monitoring claimants' health-related barriers. Fieldwork observations revealed various ways in which Personal Advisers might monitor claimants' health within their day to day practice. This included observation of claimants' health-related behaviour during one-to-one (as shown in Boxes 7.2 and 7.3) or group work sessions. When this took place, Personal Advisers were observed to ask claimants if they were ok and comfortable, or comment on their physical appearance, if for example a claimant appeared tired, anxious, or not well groomed. Being concerned about claimants' health and any risk of self-harm was also evident. One Personal Adviser described this aspect of his role as being on '*suicide watch*'. Another Personal Adviser gave an example of where she supported a claimant to receive urgent medical help:

"It was gone seven o'clock in the evening and [a claimant] sent me a text saying that he's cut his wrists, and I was obviously quite, quite concerned, didn't really know what to do, ended up having to phone the ambulance". (Personal Adviser).

Sometimes Personal Advisers would also be concerned about claimants who would attend appointments while they were unwell. This was especially evident when claimants felt worried about their benefits being sanctioned if they failed to attend their appointment.

"... [the claimant] came in and she looked awful, and she was shaking, and I said are you alright, and she said well she had a seizure the day before, so I was saying well are you sure you should be here, she goes oh yeah, I want to spend time just doing this interview and getting it over and done with (...) it wasn't until she was getting ready to leave, and she brought somebody with her, that she said I've got to hurry up now because I've got to go back to the hospital (...). So with her I phoned her up every so often to see how she were, and she was going into drug rehab, so we'd write on, we'd write notes on the system so everybody's aware of it..."

(Personal Adviser).

These types of health monitoring tasks were not necessarily perceived in this way by Personal Advisers.

"I wouldn't say monitoring, I'm just more aware of people's actions, and you know, body, body language will give a lot away, I'm very aware of that most of the time..."

(Personal Adviser).

These findings emphasised the importance of the relationship between the Personal Adviser and the claimant. Fieldwork observations indicated that Personal Advisers might use different behavioural approaches in their interactions with claimants and this is explored in the next section.

7.3 Personal Adviser and claimant behaviour patterns: styles and strategies

This section describes both Personal Advisers' and claimants' behaviour patterns during health-related exchanges. These are important because they can influence the Personal Adviser and claimant interaction. The first part of this section describes four cross cutting behaviour styles that Personal Advisers were found to adopt during their practice. The styles that were identified were: tough love, collaborative, supportive and informal. These four styles emerged from 18 different approaches which were identified in the new empirical data.

How the approaches were grouped together into behaviour styles is shown in Figure 7.2. The second part of this section describes the behaviour strategies that claimants adopted to manage their health whilst participating in an employment programme.

Figure 7.2 Four Personal Adviser practice styles

<i>Personal Adviser practice styles</i>	<i>Personal Adviser behaviour approaches</i>	<i>Data examples</i>
Tough Love	Process led	<p><i>"...we care about [claimants], you know, we've got a vested interest in them, we've got a duty of care, but we have to give that tough love, so I it's no use being nicey-nicey..."</i></p> <p>(Programme Manager).</p>
	Enforcing	
	Directive conversation	
	Persevering	
	Work focus	
Collaborative	Shared decision making	<p><i>The Personal Adviser told the claimant "we work alongside you".</i></p> <p>(Fieldwork notes-observation).</p>
	Client centred	
	Building rapport	
	Non-judgemental	
Supportive	Empathetic	<p><i>"None of this that you must do this, otherwise it's going to affect your benefit, that's the last thing you want, because then that's something else that they're going to be worrying about".</i></p> <p>(Personal Adviser).</p>
	Instilling hope	
	Monitoring	
	Nurturing	
	Supportive	
	Caring	
Informal	Friendly	<p><i>"Talk to them as a friend"</i></p> <p>(Personal Adviser).</p> <p><i>"Engage with them as though they're part of your family or as a friend".</i></p> <p>(Personal Adviser).</p>
	Informal chat	
	Humorous	

7.3.1 Personal Adviser behaviour styles

Tough Love

When adopting a tough love style a Personal Adviser took the lead in their interactions with claimants. They challenged claimants about their health-related barriers in a direct manner to begin to tailor support. They also outlined claimants' responsibilities and obligations to seek work. Whilst there was an explicit work focus within this style, the behaviour approach was also caring. Working was 'sold' as something that claimants could achieve, despite their health-related barriers. Thus, the Personal Adviser was likely to have frank and honest discussions about a claimant's abilities and explain the range of benefits that work could offer. In some cases the Personal Adviser paid less attention to claimants' health issues, once actions to resolve any barriers had been identified, and thus spent more time on claimants' work related goals.

"We do get people that honestly believe that they can't actually work, and it's, it's again it's a directed conversation about career ladders and where they actually are and where they've actually been, and it's all about trying to instil [not to let] all them skills go to waste, you've got so much to offer, you know, look at all these jobs that you'd be able to do, and it's how you actually approach it, I think a non-judgmental approach, but not too soft".

(Personal Adviser).

A 'tough love' style was also combined with elements of a Personal Adviser's enforcer role and the threat of sanctions was used as a means to coerce a claimant to seek health-related support or take part in interventions (discussed in section 7.2.1 and in Chapter Six).

Collaborative

When adopting a collaborative style the Personal Advisers were keen to build rapport with a claimant. Therefore, a Personal Adviser focused their attention on understanding claimants' health problems and sought ways in which they can work together to resolve or manage their health-related barriers better. One Personal Adviser who adopted this style made it clear to claimants during action planning activities that she also had responsibilities to complete actions on their behalf. Shared decision making and working together by expressing the term "we" was frequently used where the collaborative approach was adopted. For example, while discussing potential job opportunities the Personal

Adviser informed her client that they would:

...get something that would not impede your health (...) we need to think about what you can do (...) So we have a bit of work between us it's about getting the right job."

(Fieldwork notes-observation).

The Personal Adviser told the claimant that the action plan was a working document *"we will add and change, it's our plan to what we will do, and it's for us to work on..."*

(Fieldwork notes-observation).

Supportive

The data indicated that this style can be used to help build trust and rapport in a friendly and caring manner. It was useful to Personal Advisers' practice during assessment related tasks to encourage claimants to disclose further information about their health-related barriers. The supportive style seemed to have an association with the counselling role dimension, in particular when a Personal Adviser listened, acknowledged and affirmed the health-related barriers that a claimant had shared. For example, in this next quote where a Personal Adviser explored the possible types of work that a claimant might be able to do, she also told him that:

"What I'm worried about is too much sitting and standing and your health."

(Fieldwork notes-observation).

When adopting this style a Personal Adviser acknowledged that a claimant might not be ready for work, and stressed that it was ok for them to have time to become ready. Here, the Personal Adviser was less likely to focus on their enforcer role and focus on their enabler role, reassuring claimants that they would not be sanctioned. An example of this was seen with Jill when she supported Paul (Box 7.3).

Informal

Personal Advisers' informal disclosure of personal information emerged as a key feature of this style, although there were wide variations in the extent to which Personal Advisers engaged in such disclosure. Information shared included: brief details about Personal Advisers' hobbies, work, unemployment, family, the local area where they lived, or was of a more personal nature about their illness. Details given about their illness varied, but were generally limited. An example of this was shown in Box 7.2, when Jill mentioned her depression and stress to Bob.

The Personal Adviser asked the client; *"is your arthritis playing up? Mine is"*. The Personal Adviser went on to talk about how her condition had affected her at the weekend.

(Fieldwork notes-observation).

The Personal Adviser told the claimant that he has just had his own *'health scare'* and named his health condition.

(Fieldwork notes-observation).

Examples were also identified when some Personal Advisers shared and used their illness experience with a claimant as a tool to promote normalisation of a health condition.

"I think my personal approach is I let them know that I have got mental health problems and things like that, and also a physical disability, and that what you see isn't always what you actually get, because you can't actually see my physical and mental disabilities, so I think for [claimants] to know that I'm not normal, whatever normal is, and I'm open to share that, really breaks down some barriers and shows that really there's nothing to hide, and that we're here to actually help".

(Personal Adviser).

In addition, by sharing their illness experiences, Personal Advisers wanted to help claimants to understand that having a health condition was not necessarily a barrier to working. As already shown, drawing on their illness experience was also used to help Personal Advisers assess a claimant's situation. The use of

humour was a characteristic of this style. This was initiated by both Personal Advisers and claimants in their one-to-one sessions. Having a laugh was particularly valued by those claimants who talked about enjoying their appointments, and finding their Personal Adviser helpful.

"...I can go in have a right laugh with [Name of Work Programme Personal Adviser], we have a daftjoke, you know..."

(Claimant).

These four styles were recognisable to some degree in different Personal Advisers' practice across all three organisations, but in one organisation it was common to hear Personal Advisers and their manager talking about claimants needing "*tough love*". Whilst Personal Advisers might move back and forth between these styles during their interactions with claimants, there was some suggestion that they purposefully selected an approach when working with a claimant.

Further evidence of different types of Personal Adviser styles emerged in an interview with a manager. This manager discussed how Personal Advisers had different behavioural approaches, and that these were helpful for deciding which claimants might be more suited to see a particular Personal Adviser.

"... Other people who are in, well I've sort of observed their styles as they go along, and we then, in terms of caseload, work out who should see whom, whether it should always be the same person seeing somebody..."

(Manager).

7.3.2 Claimant behavioural strategies

This section describes four ways that claimants adopted to manage their health and two key behavioural strategies whilst they participated in an employment programme.

Accessing support

There were four ways identified in the data illustrating how claimants might manage their health. Support was accessed via internal sources: a Personal

Adviser or internal provision, and external sources: personal support including family members and friends and NHS services.

Seeking Personal Advisers' support

Some claimants spoke about the value of being able to get in touch with their Personal Adviser if they needed support. One claimant described his Personal Adviser to be more like a “care worker” or “support worker” than an adviser.

"think I'm going to have a word with (name of second Adviser), I'm going to see (name of second Adviser) tomorrow, so I'm going to ask her what, because I don't want it to go how it was with my previous employer, because there was no help, no support, no understanding, and that affected me health as well, so I don't really want to ever get into that state again."

(Claimant).

One claimant was also observed to wait around after a group session to talk to her Personal Adviser. This Personal Adviser later explained that this claimant had disclosed personal information about her childhood after thinking about this during the group activities.

Use of internal provision

Internal support provision supported some claimants to manage their health. For example, views expressed by claimants (observed during a CMP group session) showed that they were finding the programme helpful, particularly in learning how to manage their health condition better. Comments made by claimants during the session were: *"doing a lot of good"*, *"feeling more confident"*, *"seeing more progress"* and *"help me to relax"*. Some claimants attributed positive health effects to their attendance at group activities that were offered by their programme. These interventions included, for example, job clubs and motivational courses which were led by Personal Advisers. Although these interventions were not specifically health-related, claimants talked about how these provided a regular routine, structure to their day and social interaction. These views were described to be particularly helpful by claimants who experienced anxiety and depression.

Use of external support

Utilising external support was a strategy adopted by some claimants to relieve their anxiety when they were required to attend or have involvement with

employment programmes. Therefore, some claimants opted to bring a family member, friend, partner, or support worker to their Personal Adviser appointment for support, or asked them to contact Personal Advisers on their behalf. For example, one claimant was observed to be accompanied by her elderly mother, who escorted her when she left home, because she was too anxious to travel on her own following the death of her father.

"...we have people coming in with their support workers, outreach workers, it happens regularly..."

(Personal Adviser).

External health-related support

Several claimants talked about seeking healthcare advice which was related to their health condition, broader impact of the welfare reforms or their challenging life circumstances, but did not specifically relate this to their engagement in the employment programme. Many claimants made reference to a recent appointment with a GP or involvement with other NHS healthcare professionals during their interactions with their Personal Adviser, group session or research interview which illustrates their ongoing health-related needs. The experience of being unemployed, in receipt of benefits with limited financial resources was also described to be stressful.

"(...), it's stressing me because I'm really stressed, even like yesterday I had an appointment at the hospital, the way I was feeling when I went there first thing I said, I told the GP that I would like her to check my pressure, and she did, she said your pressure is high, what's wrong?."

(Claimant).

However, Personal Advisers' practice could also be associated with claimants experiencing negative impacts on their health. Therefore, two opposing claimant behavioural patterns emerged as strategies to support their health. These were 'keeping quiet' and 'fighting their own corner'.

Keeping quiet

Some claimants talked about withholding information during an interaction with their Personal Adviser to protect their health. Choosing to 'go through the motions' or complying, to give the impression of engagement, could be used as

strategies to manage their health; for example, for self-protection, avoidance of stress or the threat of a sanction because this could then impact further on their health. Some claimants also explained how they had a better understanding than their Personal Adviser in terms of what would help them remain well, and therefore might carry on doing what they wanted in secret rather than following their Personal Advisers' recommendations. Therefore, programme appointments were attended under a form of silent protest, because a claimant perceived that the Personal Adviser's intervention or suggestions were not to be in their best interest.

Fighting their own corner

Where claimants felt well enough to work, but perceived, or were told by their Personal Adviser that were not fit, there could be a need to assert their abilities, fitness and desire to work in order to initiate employment support. I observed a number of claimants doing this in practice. Sometimes this involved seeking support from another Personal Adviser who was also involved, for example, at JCP who would advocate on their behalf.

"[The Personal Adviser] told me that she didn't think I was fit for work and she were worried about putting me on the programme and I actually explained to her that I needed to do this programme and so she were really apprehensive and then she booked me into see somebody..."

(Claimant).

"I think she was very surprised when I was there, she says I don't know what you're doing here, she says I think if I was you I think I might have just stopped at home, and I said I don't want that."

(Claimant).

The Personal Adviser talked about a client who had recently had a stroke, and arrived for her appointment with a personal written statement about her capabilities to work.

(Fieldwork notes-observation).

A few claimants also spoke about their concerns and worries about the impression their Personal Adviser might have about their attitude and fitness to

work.

"At first I thought [my Personal Adviser would think] I'm lazy, not fit for work, bringing excuses (...) I'm now happy, but the first time [I thought he would think that]you're no good, you're not fit"

(Claimant).

In summary, claimants were found to adopt a variety of different strategies to manage their health in relation to their participation in employment support provision. Importantly, claimants were found to vary in the extent to which they engaged with their Personal Adviser around this agenda. This variability appeared linked to claimants' perceptions of their Personal Adviser's role, as discussed in the next section.

7.4 Personal Advisers' role perceptions

This section describes how Personal Advisers perceived their role, and explores the factors that were found to shape their practice.

7.4.1 Defining their purpose

Personal Advisers often described their primary role as helping someone move into, and to sustain, work. Some Personal Advisers also highlighted their responsibility as an 'enforcer,' to ensure claimants fulfilled their benefit entitlement obligations.

"My role is more about getting that customer work ready, ready for the labour market, to understand the implications of if you don't go to work you don't get paid, this is what it's about."

(Personal Adviser).

A number of the Personal Advisers also mentioned having an association with a counselling type role.

"...we feel like counsellors instead of employment support, employment advisers, we just feel that we're sat there listening..."

(Personal Adviser).

However, while counselling was not typically described as being part of a Personal Adviser's job description, this aspect of their role could be seen as justified. Two Personal Advisers felt it was acceptable if they had some prior

counselling training. The importance of having role boundaries when performing this role was stressed by one of these Personal Advisers.

Many of the Personal Advisers also expressed their passion, commitment and care in helping claimants to have a better quality of life, often emphasising that the value of helping someone move forward was equally important as facilitating someone to secure work.

"...I am more about helping people, and I'll say to someone, if they come to us for six months or a year, if I've got that person a job it's a bonus for me and it's a bonus for them, but if I've helped that person in that year I feel I've done me job anyway, personally, because I'm, whether I hit me target or not, I think it is more about helping people than it is getting people into work to be honest..."

(Personal Adviser).

As already shown, it was not unusual for Personal Advisers to be involved in listening, advising, and trying to seek solutions to help claimants manage their everyday problems. However, taking on a caring approach, and becoming involved in the complexities of claimants' lives could pose risks. For example, being overly concerned about a claimant's health could cause a Personal Adviser to engage in activities that stretched beyond their role boundary.

"... like a (claimant) came to me last week and he'd got no money for food so I lent him 20 quid, well it were the week before and he paid me back last week, so I know that's a bit above and beyond, but obviously I couldn't see someone go hungry for a week".

(Personal Adviser).

"... [My Personal Adviser] works very hard, I mean she even phoned me up nine o'clock one night, because she were doing me CV at home, I mean she didn't have to do that at home, but she was doing it because it needed to be in for the, it was something that was last minute and it needed to be in for the very next day, (...) I just think, I think she's been brilliant".

(Claimant).

Sometimes this type of practice was viewed positively by claimants, Personal Advisers and managers, and perceived as "going the extra mile".

"... [the Personal Adviser's] lunch is at 12, she'll continue with a (claimant) and not end it, you know, and get them out, she'll continue until she's actually finished, so she's, she doesn't mind if it eats into her time, because she thinks that the (claimants) deserve that time".

(Manager).

Some Personal Advisers felt that adopting an informal style and sharing their own illness experiences could support their practice as shown in section 7.3.1. During my fieldwork observations, Personal Advisers often shared their illness experiences with me. These experiences were felt to be of value in their practice, for example, in providing a deeper level of understanding about what claimants might be experiencing. Being able to manage their own health condition in work was also used as a positive selling point with claimants. Conversely, on occasions a Personal Adviser's own illness experience was shown to impact on their judgement about a claimant's ability to work, and there was a risk that this could be inaccurate.

When Personal Advisers were asked about any differences between their own role, and that of a healthcare professional, their views were expressed in two ways:

i) That their role was to offer employment support and not to address health:

"my role is more about getting that customer work ready, ready for the labour market, to understand the implications of if you don't go to work you don't get paid, this is what it's about. In a way my role is not as pleasant as the health professionals, because they get to chat on a one-to-one basis, encourage that person to do X, Y and Z to improve the health condition, whereas I am no, you've got to do this to get a job, this is what you need to do to maintain that job."

(Personal Adviser)

ii) That they had a partial, legitimate role in supporting claimants' health, but there were limitations:

" well I think that would be purely to focus on somebody's health, and my role as an adviser is to find people suitable employment, and really to think well yeah, people might come in and go I might be depressed or what have you, but I'm sure that, you know, and to talk to people about the benefits of working, that there might be hidden benefits, like the social aspect, for people that are depressed and they don't really get out the house and really meet new people, and to turn them around really." (Personal Adviser).

However, when these views were explored further within cases, it was evident that some of the Personal Advisers, who spoke about their role being employment focused, did nevertheless provide health-related interventions. This suggests that they did not necessarily perceive some of aspects of their role and interventions to be health-related.

7.4.2 Being prepared to identify and address health-related needs

Personal Advisers had varied levels of knowledge about the health conditions that claimants experienced. Consequently, some Personal Advisers talked about a range of strategies that they employed to gain a better understanding. This included: drawing on the illness experiences of claimants they had worked with, or relatives and friends, or indeed their own experiences. Internet searching was frequently mentioned as a valuable resource for learning about health conditions.

"...a lot of the time customers do come to us with health concerns and we're like we've never heard of them, we're like what's that, and the customer sits and tells us what they are. (...) One of my customers, they've got a disease that is attacking the bones, I've never heard of it before, really long name, couldn't even tell you what it was, but it's basically it eats your joints away, and he's actually been found fit for work, which is really ridiculous, but he was telling me all about it, he was sat there explaining to me what it does and how slowly but surely you have no bones left, and it's just like wow, it's really interesting, so I went away, Googled it and found all the information on it, so it's really interesting. So that's, that's my main point of information finding, Internet or books".

(Personal Adviser).

In addition, one of the provider organisations had regular team meetings where claimant cases and problems could be discussed and potential solutions explored. Consultations with healthcare professionals with internal or external services were also reported to be sought by some Personal Advisers.

Training

Overall, Personal Advisers spoke positively about any health-related training their organisation had provided and the potential for further opportunities. An interview with a programme manager revealed that her team had the flexibility to review their training needs in their appraisals. When talking about their

training needs, some Personal Advisers felt that having a better understanding about mental health was important. This view was also mirrored by some claimants.

"I think maybe the different types of mental health, how to deal maybe with people with schizophrenia, bipolar, because bipolar is totally different to depression, bipolar is, it's your extremes, extreme highs, extreme lows, obviously schizophrenia that's totally different to everything else, and it would have been how to handle those, customers with those disabilities..."

(Personal Adviser).

Personal Advisers also spoke about the need for training to be able to engage in a counsellor role. One Personal Adviser was supported by her manager to complete a counselling course, and others were involved in some form of counselling training. Overall, there appeared to be little consistency in the training that was provided across organisations. None of the Personal Advisers were engaged in the professionalisation agenda training which was described in Chapter Three, and most had not heard about this. Thus, the extent to which Personal Advisers were prepared and equipped to work with claimants who had health conditions varied both between organisational contexts and between individuals working within the same organisations.

Some Personal Advisers struggled to provide support to a claimant whom they assessed, or suspected had a health-related barrier, but who did not want to address this. Sometimes Personal Advisers tried to resolve this issue by adopting an 'enforcer role' and coerce a claimant to take up health-related support as shown in Chapter Six, however, this action did not necessarily resolve these difficulties.

Time

A key facilitator that was found to support Personal Advisers' practice was having time to get to know a claimant. Engaging in both formal and informal conversations was often seen as necessary to gain a better understanding about how a claimant's health condition affected their life, and ability to work. Having time was also associated with enabling Personal Advisers to feel more comfortable to broach sensitive health-related issues with claimants, for example, in raising concerns about an individual's physical appearance as

described in section 7.2.2. However, there were a number of factors which were found to impinge on the time that Personal Advisers could spend with a claimant, for example, structural issues such as large caseloads and demanding contractual administration related tasks. In addition, it was common for claimants to miss, or arrive late for an appointment, and this had a knock on effect on Personal Advisers' daily schedules and work demands. Therefore, Personal Advisers needed to be able to juggle their practice and contractual demands.

Targets

All of the Personal Advisers observed in this study had to achieve job outcome targets either individually or as a team. However, it was interesting to observe a sharp contrast between the way in which job targets and the pressure to 'sell' job vacancies to claimants were discussed in one organisation's team meetings and how Personal Advisers later presented vacancies to claimants by using a 'softer' and more encouraging approach. Thus, in this case, any potential pressures arising from these target performance requirements were not overtly displayed by the Personal Advisers in their day to day practice. However, one Personal Adviser in this setting said that on occasions targets could influence the way he presented potential job vacancies to a claimant.

"... I think, you tend to go away from the customer more, because I mean if you've got a customer who's thinking do I really want to work at McDonald's or not, and you say look, it's more a step on the ladder for you, and it does help them, because obviously getting, getting work does help your confidence etcetera, but yeah, you think, as well as thinking oh, I need to help this person, you're thinking well if that person does start on Monday I've hit my target this month, so yeah, rather than solely thinking help the customer, help the customer, at the same time thinking I'll help the customer, but if he starts work at this one I've got one more towards my target this month..."

(Personal Adviser).

Accessing health-related support

Some Personal Advisers struggled to access health-related support and this became an obstacle to helping claimant's progress towards work. In the absence of identifying suitable health-related provision, one Personal Adviser was unable to offer anything to her claimants other than more time to talk, but as shown, having sufficient time was not always possible. This Personal

Adviser also suggested that a potential solution to address this issue was to employ specialist counsellors to work directly within their programme.

"(Name of Personal Adviser)'s quite good at helping the customers with mental health, but we've only got time to have her programme running for two days a time, so we've got that many customers, it's not a long-term programme, and again she's not trained to do that counselling or anything long-term, so she can only deliver what she knows really, so it's quite, it's quite a difficult one, and that's the one where we're all stuck at, we all don't know what to do with these customers, they're kind of sat in a pot".

(Personal Adviser).

Being resilient

There was a need for many Personal Advisers to be both creative, and resourceful in their day to day practice. When Personal Advisers attempted to formulate an accurate assessment of a claimant's health-related barriers, my observations revealed examples where Personal Advisers demonstrated skills in being able to ask claimants important and relevant questions relating to both their health and work related issues. Seeking possible solutions to claimants' health-related barriers was also evident, but not consistently observed. There were examples where a Personal Adviser's solutions bypassed a barrier rather than sought a solution. For example, when a claimant explained he could experience panic attacks on a bus, the Personal Adviser suggested he worked near to his home so he could walk to work, rather than exploring other solutions that might tackle his panic attacks.

Personal Advisers' practice could pose risks to their own health, and this was of particular importance for those who had a health condition. For example, one manager spoke about being concerned about a Personal Adviser who had depression and had become too emotionally involved in work tasks. Overall, many Personal Advisers had experienced emotionally challenging events in their practice, and some worried that programme processes or interventions might exacerbate, or cause harm to a claimant who may already be vulnerable.

"...a customer the other day, and he didn't want to come to his first appointment with us, and it's like well you've got to mate, I've got to get the paperwork done and get you signed on to programme, and you know, I thought, well he was very upset and he was very irate, and I

thought he might do something to, might hurt himself, and I'm just trying to do my job..."

(Personal Adviser).

There were some examples where provider organisations employed coping mechanisms to help Personal Advisers manage these difficult situations. One provider organisation was observed to follow a structured safeguarding protocol if claimants were felt to be at risk. While another Personal Adviser spoke about the use of humour in their team meetings as a way of coping with claimants' complex issues.

In summary, Personal Advisers had varied perceptions about their role and boundaries of support in relation to addressing claimants' health-related barriers. The extent to which they were prepared and equipped to support these claimants varied, and some organisations provided counselling type training to support their practice. Structural factors could reduce the time that Personal Advisers spent with claimants. Importantly, the emotional impact of Personal Advisers' work with claimants who had health conditions could be challenging, and this is an area of their practice that may be particularly beneficial to monitor if a Personal Adviser also has a health condition that could impact on their work.

7.5 Claimants' views of Personal Advisers

This section explores claimants' views of their Personal Adviser, and whether the support received in relation to their health was perceived as helpful or not. It is important to note that some claimants had involvement with a Disability Employment Adviser at JCP, as well as Personal Advisers within their programme.

Claimants expressed varied views about the support provided by Personal Advisers. In some cases claimants' views were linked to a Personal Adviser's age; enthusiasm; whether they were perceived as "*down to earth*" or had similar life experiences. In-depth interviews with claimants revealed that there were varied expectations and preferences about how Personal Advisers should respond, to their health and also the legitimacy of this aspect of their role.

When claimants talked about any differences between a Personal Adviser's and healthcare professional's role, their views were expressed in two ways:

i) That the Personal Advisers' role was for employment support only. Claimants described distinct differences between the Personal Adviser's and a healthcare professional's role:

"oh well like the employment adviser, they advise you about work, to get back to work, while the healthcare, they will be 100% on your, your health issue, the necessary advice that you need to get back your health [...], they will address those issues, while the adviser just on jobs".

(Claimant).

"....I think they're both two separate, I wouldn't, they've both got their own job to do if you know what I mean, and I think (name of current provider) I would, I wouldn't even think about anything health-wise there (...)"

(Claimant).

Personal Advisers were also seen to have limited understanding and ability to address health-related issues in comparison to a healthcare professional:

"you know, for person like me who's got like physical condition, it's much easier to talk to person like, you know, to a health, health professional, rather than to someone, you know, like others that don't really know anything about it anyway, and you know, it's nothing, they can't do nothing about it anyway, they can't really advise me on it, to have that health professional around to like advise and that... "

(Claimant).

ii) That Personal Advisers had a partial and legitimate role in supporting claimants' health;

" I think (name of first adviser) might have done, you know, a few things, because like I said her sister suffers like the way I do and did, and just like, nothing like major, but like you know, little bits and bobs that you know, if you do this then you're better off and you wake up in the morning this and that, but nothing like from medical, you know, person, because they're just agents in an agency..."

(Claimant).

The quality of the relationship a claimant had with a Personal Adviser was also important. The in-depth interviews also revealed that although a claimant might describe their relationship with their Personal Adviser as positive, this did not necessarily mean that they also felt they had a legitimate health-related role.

Helpful practice

Some claimants described Personal Advisers' practice as helpful if they were asked about their health problems and their account was taken "*on board*" and believed. Many claimants also talked about the importance of Personal Advisers showing concern and having an understanding attitude. Several claimants described their interactions with a Personal Adviser as positive, quite informal, and enjoyed having a chat with tea or coffee.

"I'd have gone every day, I mean my friend sometimes phoned up and said I've just been to the Work Programme, I haven't got to go back for two weeks now, wahay, brilliant, but I, I will say the other way, I'd say like if, I'd go and see (name of Personal Adviser) every day, because we can have a good laugh, a bit of a chat like"

(Claimant).

Personal Advisers' ability to find the 'right' work was also important for some claimants. Some claimants talked about Personal Advisers being "*dedicated*" to help them to find work. One claimant described her Personal Adviser as a "*Fairy Godmother*", because of the support received to move into work successfully. The Personal Advisers' role in talking to prospective employers about claimants' health conditions on their behalf to "*get a foot in the doof*" was also talked about positively by some claimants. Some claimants, both in interviews and during observations, talked about their desires for a work placement. These placements were described as an important step to getting back into work

"It's a very good plus sign, big plus for me"

(Claimant- phone conversation).

However, some of the same claimants had concerns about how work placements were discussed or arranged:

"She wasn't interested to be honest, I was only there ten minutes at (name of provider organisation) so she was happy to bung me on a work placement and so she won't see me for a few months".

(Claimant- telephone conversation).

Unhelpful practice

Some claimants felt that a Personal Advisers' practice was unhelpful when they appeared to be "going *through the motions*", or were apprehensive about a claimant taking part in their programme because they were "*not fit for work*". Several claimants reported to have irregular contact with a Personal Adviser and this could make them feel anxious.

Personal Advisers' adoption of an informal style and disclosure about their own health condition was not a positive experience for one claimant. In this case the Personal Adviser was viewed to overstep role boundaries:

"I can't remember the [Personal Adviser's] name but she talked a lot about her personal problems and her family and because I have got personal problems in my family she seemed to want to sort of like book a separate appointment to talk about her problems which were really unprofessional like".

(Claimant).

There was also some indication that claimants' impressions of Work Programme Personal Advisers could also become entangled in their views about the Work Programme's payment model.

"... they don't really see you, they just see the cash that comes with you, you know, you're money to them, aren't you..."

(Claimant).

7.6 Conclusion

This chapter has examined the micro-level interactions between a Personal Adviser and a claimant within the Work Programme and Work Choice. The extent to which Personal Advisers appeared to be capable of assessing and addressing claimants' health-related barriers seemed to reflect a number of factors. These included: time to get to know claimants to build an effective

relationship; access to up to date information about a claimant's health condition; health-related knowledge to be able to make sense of claimants' health conditions and related barriers; time to help claimants address any barriers; prior experience of working with claimants; peer support; and access to health-related support options, both in-house and externally. These requirements illustrate the complex nature of the Personal Adviser's role, and level of support and skill they are likely to require in their practice. In the absence of such support, and competence there are risks that Personal Advisers will overlook claimant needs or engage in tasks that may hinder or harm a claimant's progress towards working. Personal Advisers could also compromise claimants' health.

This chapter has explored the key health-related tasks and associated role dimensions that Personal Advisers performed that were documented during the fieldwork observations and talked about in research interviews. This was especially evident in relation to the 'mixed messages' that both claimants and Personal Advisers received about a claimant's fitness for work. These 'messages' may also be directly driven by a Personal Adviser, as the findings suggested that they can help to promote either a wellness or illness perspective during their interactions with claimants.

When Personal Advisers tried to support claimants' health needs they often sought or used signposting to help claimants access healthcare professional led services, more typically GP's. In addition some Personal Advisers provided their own interventions which included health-related advice. However, the findings have shown that accessing health-related support may not be straight forward, and some Personal Advisers were reliant on other resources both internal and external being made available. Therefore, in some cases, Personal Advisers were at risk of ignoring claimants' health-related needs if they did not have access to health-related support options or the knowledge about how best to support them. In some cases, a claimant's health was also affected by the wider impact of welfare reforms. This led some Personal Advisers to help claimants address a wide range of problems. Consequently, this stretched a Personal Adviser's role boundaries, which do not appear to be clearly defined, especially in relation to supporting claimants' health issues.

Both Personal Advisers and claimants have shown to have mixed views about the legitimacy of the Personal Adviser role in relation to health, and whether health issues should be primarily dealt with by healthcare professionals or not. The findings have also shown that claimants can have different views about whether Personal Advisers are competent to provide health-related support. Therefore, while some claimants were likely to seek support from a Personal Adviser for their health, others felt this was better addressed by a healthcare professional. The level of claimants' health-related disclosure varied. Some claimants disclosed health information during a wide range of programme contexts. Therefore, a Personal Adviser may need to be prepared to engage in different roles and adopt different strategies at various stages in a claimant's programme journey. Conversely, some claimants chose to withhold information if they felt it was in their best interest. Thus, Personal Advisers' practice demanded considerable skills, and the ability to respond creatively. The findings presented in this chapter have raised a number of questions concerning the role of the Personal Adviser which concern both policy and practice issues. These will be explored in the following chapter.

Chapter Eight: Supporting claimants' health-related needs in the new welfare-to-work era: integration of findings across macro, meso and micro level perspectives

8.1 Introduction

This chapter integrates the findings from Chapters, Five, Six and Seven to answer the nine research questions set out in Chapter Four. These overarching findings are drawn together through a synthesis of the findings generated from: the analysis of secondary data sources (that pre dated the Work Programme) which explored the Personal Adviser's role in supporting claimants with health conditions; the analysis of the Work Programme bid documents; and the new empirical data (produced via observations and in-depth/informal interviews) which involved the welfare-to-work arena and practice in the Work Programme and Work Choice.

This study set out to explore the role of the Personal Adviser and health-related support provision in the newly emerging welfare-to-work landscape. The primary research question was: What role does the Personal Adviser have in supporting the health of claimants with long-term illness? A qualitative methodology underpinned by ethnographic principles was implemented. The study design aimed to take into consideration the macro, meso and micro-level factors that characterise the policy arena, provider organisations that provide employment support and front-line practice, and that shape the role that Personal Advisers play.

This chapter has two sections. The first section begins by revisiting the theoretical framework and explaining how this helped to identify key themes for exploration in this study and to guide the analysis and integration of data. Consideration is also given to how the trustworthiness of this study can be judged. It then moves on to discuss the transferability of the findings, evaluates

the strengths and limitations, and relevance and importance of the study. The second section discusses and integrates the findings in relation to each of the nine research questions. The extent to which each question has been answered and the confidence in the claims made is also outlined. The chapter concludes by raising concerns about the complex nature of the multidimensional role of the Personal Adviser, and expected scope of their practice in relation to health.

8.2 Revisiting the theoretical framework

The theoretical framework was described in Chapter Two. This was drawn from Lipsky's (1980) theory of street-level bureaucracy. Lipsky's (1980) theoretical insights were helpful in gaining initial understandings of how frontline workers, such as Personal Advisers practice and indicated what aspects were important to explore in this study. Lipsky's (1980) insights revealed the common dilemmas that frontline workers had been observed to experience whilst having high levels of discretion and autonomy in delivering policy objectives. In relation to addressing claimants' health-related needs, the street-level bureaucrats' role of discretion and autonomy, patterns of practice, advocacy and 'gatekeeping' role dimensions were key themes for exploration in this study.

The findings presented in the previous three chapters largely concurred with Lipsky's (1980) identification of high levels of discretion and autonomy in frontline workers' practice, especially in terms of the support that Personal Advisers decided to offer and provided to claimants in relation to health. However in the primary research, having a high degree of autonomy and discretion appeared to encourage some Personal Advisers to extend their role (sometimes unbeknown to their manager) and support claimants in ways which at times stretched beyond their role boundary. One area of Personal Advisers' practice where discretionary judgement was particularly evident in the primary research involved the way in which they reflected on their own illness experience, or those of others, when deciding how to support a claimant with a similar illness.

Lipsky's (1980) theory was also useful in exploring and extending the different role dimensions that Personal Advisers adopted. For example, Lipsky's (1980)

definition of the advocacy role incorporated the workers' '*...use of knowledge and skill, and position to secure for clients the best treatment or position consistent with the constraints of the service*' (p72). However, the findings in the theory review and primary research revealed that the advocacy role could be adopted by a Personal Adviser in the absence of having adequate knowledge or skill about a claimant's health condition. Therefore, while the outcomes of adopting this role might be perceived by a Personal Adviser to suit the best interests of a claimant, (for example, if a claimant stated that they felt unfit to work, despite having been medically assessed as fit, and a Personal Adviser agreed with his/her position), it may not meet the intended policy objectives, or goals of the organisation in helping a claimant prepare for work. It may also inappropriately medicalise a claimant. Therefore, a Personal Adviser's adoption of this role may have unintended consequences not only for the claimant, (if they subsequently receive little support to move into work), but for the provider organisation who is required to deliver job outcomes. Moreover, when some Personal Advisers in the primary research used their discretion to adopt an advocacy role, this did not always appear to be explicitly linked to the constraints of their service's resources as defined by Lipsky (1980). Instead this role sometimes appeared to have been associated with how a Personal Adviser constructed the nature of a claimant's illness and whether they judged an individual as unfit to work. This raises questions about the acceptability, accuracy and interpretation of any medical assessments and related information that both Personal Advisers and claimants have received. If such information is kept up to date and provides consistent messages around fitness for work, the need for Personal Advisers to adopt a potentially conflicting advocacy role may be lessened. Lipsky's (1980) insights about how street-level bureaucrats enacted an advocacy role and could be undermined by: large caseloads; restrictions of organisational resources; or limited resources, seemed to concur with the primary research findings to some extent, especially in relation to some Personal Advisers' struggles to access health-related support provision.

Lipsky (1980) identified a number of different client strategies that were adopted to create a good impression when interacting with a frontline worker. The primary research concurred with his observations regarding clients' passivity in complying with frontline workers' requests. However, this research extended his theory in two ways. Firstly, by revealing the way in which some claimants

displayed passive behaviour when they overtly agreed with a Personal Adviser's recommendations, to give the impression of conforming, when in reality they did not intend to do this as a means to looking after their own health. Secondly, claimants demonstrated that they could assert their agency by disagreeing with a Personal Advisers' assertions that they were not fit for work. A finding that does not concur with Lipsky's (1980) theory relates to clients' acceptance of the legitimacy of the frontline workers' role. The primary research found that while some claimants perceived that Personal Advisers to have a partial legitimate role in addressing their health, others did not. The legitimacy of frontline workers' roles and boundaries is an area that was not fully explored by Lipsky. Given that Personal Advisers are crucial to supporting Governments' policy objectives, particularly those that relate to conditionality, these are important areas for further exploration.

8.3 Trustworthiness

Given the debate about how qualitative research should be judged, as discussed in Chapter Four, I have drawn on key concepts within Hammersley's (1992), Mays and Pope's (2000) and Mason's (2002) quality assessment frameworks to allow the reader to consider the trustworthiness of this study. Chapter Four provided an audit trail of the research process which aimed to provide transparency and clarity in terms of why and how the data was selected, gathered, analysed, interpreted, and how conclusions were drawn. Therefore, here my focus is on reflexivity, transferability and the relevance and importance of the study's findings. In addition, I highlight the key strengths and limitations of the methods adopted.

Reflexivity

Reflexivity has been defined as: *'An attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process'* (Malterud 2001, p484). My reflexive account of the strategies that were adopted throughout the study is described in Chapter Four. These included: having regular supervision, writing a research diary and memos following my observations, interviews and data analysis. Conversations with peers were also valuable, not only for debriefing, but in offering critical feedback following presentations of my preliminary findings. These reflexive

strategies helped to ensure that the findings were based in the data and not my prior experience.

At the start of this study, I reflected and wrote about my professional and personal experiences (Chapter Four). This included my work in a welfare-to-work setting, and how I dealt with my work related injury and loss of job. I also considered my previous role as an Occupational Therapist, and how the combined knowledge from these different experiences might be an asset or a risk during the research process. In terms of strengths, my experiences offered a degree of insider knowledge and familiarity with the culture and language used within welfare-to-work programmes and the role of the Personal Adviser. Similarly, as I had talked and listened to many claimants who had health-related needs about their barriers to employment, I could identify with some of their challenges. However, I was aware of the importance of setting these experiences aside (Malterud 2001) to ensure I did not prejudge or introduce bias. The importance of this was illustrated during my first observation. This involved a Personal Adviser and a male client who was in a wheelchair. During this session, there was a lengthy discussion about the problems this gentleman had with his local Occupational Therapy Department and his Personal Adviser offered solutions to help address this. Throughout this meeting, I was aware that I could have easily helped this client to resolve his difficulties, but I chose not to intervene. Instead, I focused on observing how the Personal Adviser and client talked about these issues.

My early reading covering the existing theory about frontline workers' practice (Lipsky 1980) and related Personal Adviser research, as described in Chapters Two and Three helped me to gain new insights into Personal Advisers' practice and how this role is likely to operate. I also explored the wider literature concerning the lived experiences of long-term illness and illness perceptions. This knowledge supported the development of my theoretical framework (Malterud 2001) and further stages of the research process. It also helped to show where my findings were supported or contrasted with the existing evidence, or appeared to offer an original contribution.

Transferability

Description of the context in which a study takes place is essential to enable a reader to assess the transferability of any claims made (Guba and Lincoln 1985). Overall, my findings were drawn from a wide range of settings involving different employment support provision and Personal Adviser roles. The review work, presented in Chapter Five, covered a range of settings and different employment programmes. These included delivery by the private, non for profit and JCP organisations. Similarly, the Work Programme bids analysis presented in Chapter Six included all of the Primes, while the practice-level research covered both Work Programme and Work Choice and mainly involved the non profit sector. Additionally, a diagram (Figure 7.1) and detailed descriptions (Boxes 7.1, 7.2 and 7.3) of the settings in which interactions between Personal Advisers and claimants were observed have been provided. Further context details are given in Chapter Four in table 4.3 and Table 4.3 which outline the stakeholders consulted during the study period, thereby illustrating the scope of the data generation achieved. Thus, the adoption of an ethnographic approach provided opportunities to draw on a wide range of data sources.

There is a degree of confidence that the issues raised in relation to Personal Advisers' practice and the more general provision of support to claimants with health issues have wider relevance to the Work Programme and its likely success. For example regarding issues relating to how NHS health services are integrated with the Work Programme. There may also be value in exploring whether, and how the generic claims, might be relevant to other settings where similar supportive job roles operate. For example, a new key worker role, (described in Chapter Nine), which aims to assist claimants who leave the Work Programme, may encounter similar challenges to those found in this study if there is with limited integration with health services. However, there may be limitations in terms of the transferability of my specific empirical claims which were based on the practice-level investigation because of individual differences in the organisation's culture, structures and processes. Hence, these findings may not be generalisable to other settings. This study offers new theoretical contributions to knowledge which build on the existing theory about the Personal Adviser's role in relation to their practice with claimants who have health conditions. In addition, it adds new knowledge about the

multidimensional nature of this role in relation to health, and insights into how the issues surrounding claimants' health are interpreted and responded to within the new welfare-to-work context.

Relevance and importance

This study has added to the existing knowledge about how Personal Advisers assert their agency and discretion in their day to day practice. This study has provided new knowledge and insights into how the issues surrounding claimants' health are interpreted and responded to within the new welfare-to-work context. It has also extended and contributed new knowledge about the multidimensional role of the Personal Adviser in relation to health. These findings are noteworthy given the central role that Personal Advisers have within the current welfare reforms, and expectation to perform as both enablers and enforcers. An original contribution to knowledge has been made in the typology of behaviour strategies relating to claimants' responses made in their interactions with Personal Advisers in order to manage their health. These findings are likely to be beneficial to the practice developments of the Personal Advisers' role. They also have important implications for policy, practice and further research which are described in Chapter Nine. It is important to note that there was considerable interest and willingness of people to engage in the study including stakeholders those across both health and work provision. This suggests the pertinence of the topic and issues that I was investigating.

Strengths and limitations

The adoption of a multilayered ethnographic methodology was a key strength. This provided a holistic view of the factors that might affect the Personal Adviser's role, and provision of health-related support because a wide breadth of data sources were used. By drawing on these different data sources, I had the added benefit of being able to corroborate and test out early findings; for example, by using informal member checks conducted through consultations with stakeholders within the welfare-to-work arena. This approach also ensured that there was flexibility and refinement of the study over time. This approach was essential given the change in government and employment support provision. Additionally, it allowed further investigation of different data sources, some of which only became known as the study progressed. For example, I only became aware of the Work Programme bid documents whilst following a

claimant's internet forum. Moreover, this approach helped to ensure there was '*comprehensiveness*' in the data gathered which supported my confidence in answering the research questions (Mays and Pope 2000, p51), especially as findings in one element of the study could be tested in another. For instance, the eight Personal Adviser role dimensions that were identified in the realist review work in Chapter Five helped to inform the interview guides employed for the new empirical work.

To explore if the empirical practice-level findings were reflected in the wider community of Personal Advisers, alternative methods were considered during the study's planning stage (focus groups and an email survey). However, as the study progressed it was decided this would not be possible due to time constraints of the study.

In terms of limitations, the amount of data that was gathered during the study period was considerable. Therefore, decisions needed to be made about which analysis methods and techniques could be applied. This required exploration and learning of new techniques and evaluating their strengths and weakness. It is possible that some of this data could have been explored further with more experience of the methods. There were also limitations in gaining access to Primes and private provider organisations as discussed in Chapter Four. However, this issue was addressed with the inclusion of a Work Choice provider. Given that the Work Choice programme aims to support claimants with long-term conditions, it was thought to offer valuable data and insights that could equally contribute to answering the research questions about the Personal Adviser's role, organisational supports and constraints, as well as claimants' experiences and strategies. Although not an initial intention of the study, the inclusion of this different programme revealed similarities in Personal Adviser practices to those found in the Work Programme. This finding also concurs with Lipsky's (1980) theory which found similar patterns of practice in different frontline roles across different organisational settings.

Whilst the data obtained via the observations and in-depth interviews was considered to be sufficient for addressing the research questions, the numbers of participants recruited for interviews were lower than originally planned. In general, the recruitment of claimants was challenging, and although more successful strategies were learnt over time, a higher ratio of male to female

claimant participants, most of whom received Jobseeker's Allowance (JSA) rather than Employment Support Allowance (ESA), took part in the interviews. However, these findings have highlighted the health needs of some people within this group. It was also difficult to follow some claimants throughout their programme journey, and to match claimant interviews to their Personal Adviser. This was due to: staff turnover; Personal Advisers' workloads; and claimants becoming too ill to take part, or failing to attend an appointment with their Personal Adviser or research interview. Despite these limitations the breadth and depth of the data generated rich information about the Personal Advisers practice and claimant experiences. The next section integrates the study's findings to address the nine research questions.

8.4 Integrating findings across the study elements to address the research questions

8.4.1 Research Question One

To what extent are claimants' health-related needs considered within the Work Programme policy?

This first research question was addressed via the review of the Primes' bid documents and policy related documents and discourse, in addition to the observations and interviews within the Work Programme. Much of the Work Programme analysis was undertaken when the programme was in its infancy and there was a paucity of research in this area. This component was a comprehensive analysis including bid documents that covered all of the 18 Primes. Therefore, I have confidence in the claims made in answering this question.

Overall, the analysis revealed that the Work Programme policy aims to shape employment support to meet individual needs, irrespective of the benefit received or health condition experienced. Unlike the previous Pathways to Work (PtW) policy (as discussed in Chapter Three), within the Work Programme policy, health-related support is not required to be a core element of provision. Instead, the Governments' black box approach allows Primes to determine "what works" and how best to deliver support/intervention to claimants without any prescriptive contractual requirement to provide health-related support. This analysis also found that recent policy assumes that Primes will be knowledgeable and innovative in their delivery, and expects there will be use of

specialist organisations and partnerships to help people with health-related needs move into work. Whilst these partnerships are expected to include services such as the NHS, there is no defined role for the Department of Health or NHS as in the PtW policy within the CMP as shown in Chapter Three. This suggests that the role of the NHS has been sidelined to some extent and that the Government's assumptions of integration and partnership working are risky.

Government's policy discourse, (as shown in Chapter Six) considers claimants' health-related needs to be either fairly easy to address, because they are common and manageable. In some cases, those who are 'harder to help' are seen to need longer-term support. In both cases, claimants' health needs are not considered to be severe within current policy, illustrated by the fact that people with these needs should be placed in the ESA support group following their medical assessment for benefit entitlement. Claimants' health-related needs were widely mentioned in the Work Programme bid documents, but the prominence of this issue varied, and there was commonly a lack of detail. This was particularly evident in Primes' minimum service levels (MSL) as only five out of 18 of these standards make explicit reference to addressing claimants' health prior to starting work. The primary practice-level research also found that when claimants participated in a programme the MSLs were not always fully explained in relation to health. This implies that some Primes may be exercising discretion over how, when and if they make their MSLs explicit to claimants and this clearly raises questions about equity.

The analysis of the policy documents and discourse suggests that Personal Advisers are able to perform their role in personalising support, especially in managing the additional "powers" given to ensure participation in work related activities. These activities were found to include claimants' engagement in a health-related support intervention at times. Within the Work Programme bids, the Personal Adviser is typically documented to be at the heart of delivery, '*the lynch pin*', having a central role in tailoring support for claimants who have health-related needs. However, this role is not standardised in Primes' bids, and there were variations in how these roles were described and later found to operate in practice, in my primary research. This suggests that claimants are likely to experience differential levels of support depending on which Personal Adviser they see across the different Work Programmes.

8.4.2 Research Question Two

How is health-related support incorporated within Work Programme provider organisations' offer?

The review of the Work Programme bid documents, presented in Chapter Six, enabled a detailed examination of how health-related support had been incorporated within Primes' offers. While I have confidence in the claims made, there were some areas of uncertainty relating to who might provide some of the proposed health-related support interventions in practice, as discussed below. However, some clarity about this was found through observations of Work Programme practice which is described in the following research question, though these findings were not conclusive. Overall, I found that all of the 18 Primes incorporated health-related support provision within their formal bid offer. However, there were variations indicated in terms of whether it had a work, health or integrated focused approach. There were also differences in its size, content (which is discussed in section 8.3.3) and delivery method including when support would be offered to claimants.

Although there were inconsistencies in how Primes described their support within the bid documents, there was a strong association in many of the bid statements with work outcomes. However, only one Prime used a '*work focused health-related support*' descriptor. There were varied levels of proposed investment which seemed to be limited in terms of the size of the provision. In-house, private, third sector and statutory bodies were documented within the proposed delivery. Some of this support was identified to be provided by healthcare professionals that would be integrated with the Personal Adviser role. Some healthcare professionals worked in a separate service for a specialist subcontractor, or provider organisation as a one off purchase. The details of some offers of support could not be clarified and found in the available data remained uncertain, but it was indicated that there would be some involvement of non clinical staff.

There were also variations in how, and at which stage in a Work Programme journey provider organisations proposed to provide health-related support. This included pre work and post work stages. While some Primes indicated, that support would be made available to all claimants, irrespective of their benefit type, scrutiny of Primes' eligibility criteria suggests it may not be available to all who could benefit. Again, this raises questions about equity. Thus, claimants'

access to health-related provision appeared to be largely associated with the organisations' assessment process, and dependent upon Personal Advisers who typically act as a gatekeeper.

8.4.3 Research Question Three

What types of health-related support are made available for claimants within the Work Programme?

The evidence used in answering this question has been drawn from: the review of the Work Programme bid documents, which detailed the health-related provision that was to be made available for claimants; the observations and in-depth interviews with Work Programme Personal Advisers and healthcare professionals and stakeholder consultations and observations of the wider welfare-to-work arena. However, questions remain regarding whether all of the proposed health-related support that was identified in the bid documents is being made available in practice, and how widely accessible this provision is for claimants within each programme. Therefore, some of these claims need further investigation. Thus, the new Work Programme evidence, reviewed in Chapter Nine, will help to address this question further.

Overall, a diverse and wide range of health-related support interventions were documented in the bid documents. These included both pre work and post work support through one-to-one, and group interventions. Condition management was a popular choice that was proposed by 15 of the Primes. In contrast to the previous PtW CMP, described in Chapter Three, there appeared to be more of a focus on work and job sustainability within the interventions described. Telephone support interventions (both pre work and post work support) were also identified as common options selected by the many of the 18 Primes. Some of these telephone services were to be made outside of the 9-5pm office hours and to all claimants irrespective of their benefit type with some also offering support to employers.

The interventional approaches documented within the bids included: cognitive behavioural therapy, solution focused therapy, counselling and motivational interviewing techniques. What could be perceived as more clinical interventions, ("hands on") such as physiotherapy along with specialist health assessment. Some of these had a focus on identifying claimants' functional capability including lifting tests and job matching were also indicated in some of

the bids. Health management interventions included: advice and guidance (such as pain management techniques), promotion of healthy lifestyles and encouragement of activities such as walking and healthy diets. Complementary health-related interventions such as yoga and Tai Chi were also proposed by one Prime. These interventions were indicated to be carried out through group work and /or one-to-one, via face-to-face in a range of venues or telephone support services. Involvement with employers to explore workplace adjustments were documented by some of the Primes. Ensuring claimants were signposted to an existing statutory provision, such as the NHS, was also proposed by a number of the Primes.

The primary research showed that, in practice, two Work Programme provider organisations' CMP followed a similar pattern to the NHS-led PtW CMP, with little emphasis on in-work support for claimants. These programmes were delivered by a small number of allied healthcare professionals, and one programme had waiting lists. Observations in two of the organisations revealed that all claimants had the option of accessing a telephone support service, but these services were never mentioned by any of the participants.

Personal Advisers were also observed to provide health-related support interventions for claimants in a group or one-to-one sessions; for example, giving advice on health-related topics which included: healthy eating, medication use, exercise and sleep patterns. In-depth interviews and observations also highlighted that although it was common for Personal Advisers to signpost or encourage claimants to access NHS services, especially GPs, or third sector health-related provision, there was also some selectivity in terms of which claimants received this support. In addition, in-depth interviews revealed that a minority of Personal Advisers were mandating or were considering mandating claimants to a health-related provision such as CMP or a GP. This suggests that some Personal Advisers had taken on board elements of their policy 'enforcer' role as described in Chapters Three and Five.

8.4.4 Research Question Four

What factors might influence the Work Programme provider organisations' provision of health-related support?

Insights into the factors that shaped the Work Programme provider organisations actual provision of health-related support came from the analysis

of the bid documents, in-depth interviews with Work Programme managers and healthcare professionals and stakeholder consultations as part of the wider ethnographic work. Overall, a number of factors appeared to have influenced Primes' provision of health-related support. However, there is some uncertainty as to whether this analysis has identified all of the factors. Therefore, the new Work Programme evidence, presented in Chapter Three, is revisited to highlight any emerging factors.

As the Department for Work and Pensions' (DWP) Work Programme tendering process required details about how claimants' health-related needs would be addressed, it is likely that the inclusion of health-related support provision would have been considered important and relevant by Primes. The bid document analysis also showed that offers of health-related support were influenced by the health-related needs of claimants within a Contract Package Area and gaps within local NHS services.

Perhaps unsurprisingly, the primary research revealed that financial costs were likely to have been a decisive factor that influenced some provider organisation's decisions regarding how to incorporate health-related support provision within their model. For example, one CMP practitioner reported in an interview that his organisation had been approached by potential Primes and had been asked to be included in their bid without any funding arrangements being offered. Cost concerns in relation to healthcare professionals' salaries were also raised in in-depth interviews with Work Programme managers. When talking about cost issues it was indicated that comparisons between healthcare professionals' and Personal Advisers' practices and performance, particularly in relation to the achievement of job outcomes, were likely to be influential factors for some Work Programme provider organisations when they considered the potential value of a health-related support provision. For instance, a comparison in the time healthcare professionals spent with claimants was made by one manager. Other challenges related to the need for "*confidential [intervention] spaces*" which could put "*pressure on the building*". Therefore, by offering an in-house health-related provision, a Work Programme provider organisation is likely to have to respond and meet these requirements. These may be unfamiliar within their organisation or unattractive as discussed further below.

Another factor that appeared to have influenced some Primes' provision of health-related support was the experience in determining "what works", especially from their operations in international programmes. These international experiences were explicitly referred to in the bid documents and reflected in the design of three of the four in-house healthcare professional roles, as already mentioned. While these Primes' experience may have been used to convey credibility in an increasingly evidenced based policy discourse, some of the bid documents also revealed the importance of ensuring that health-related support was work focused. For example, one of the documents cited the preferred use of an international model of CMP because it was more work focused than the previous UK PtW CMP.

The primary empirical work identified practice challenges in meeting claimants' health-related needs once the Work Programme became operational. For example, the need for an in-house health-related support service was realised in one Work Programme where Personal Advisers were struggling to help claimants to progress into employment. This was especially pertinent where there were also difficulties in claimants' accessing NHS services. Similar findings were reported in informal interviews with a group of Personal Advisers who revealed a lack of health services to support claimants with physical health conditions. This meant they were likely to be 'parked' in their service.

In my stakeholder consultations, one Work Programme manager reported they were considering employing a healthcare professional. However, they expressed a lack of understanding about healthcare professionals' practice, and knowing how to proceed with recruitment, in addition to being unaware of issues concerning clinical governance. Thus, direction was needed before this option could be taken further. This suggests that this organisation had a lack of processes to make this happen and may indicate that integration with healthcare professionals was not the norm. It also suggests that some organisations may have underestimated: the level of health-related support that some Work Programme claimants would need; the difficulties in integrating with NHS services, or the benefits that health-related support offers Personal Advisers' practice. It also implies that work to establish relationships with the NHS is unlikely to have been undertaken by some provider organisations as

shown in the bid analysis or that any attempts made were unsuccessful or limited as described in stakeholder consultations.

In contrast to the cited negative findings about the PtW CMP described above, and lack of integration with the NHS, one Prime proposed, in its bid document, to draw on the legacy of a NHS-led PtW CMP and highlighted its value through its established relationships with local GPs. This indicates that there were expectations that some of the staff who had been employed in an NHS-led CMP would want to be retained, and be able to rekindle/build GP relationships whilst working for a non-NHS led organisation.

8.4.5 Research Question Five

How do providers' organisational culture, structure and processes support/hamper Personal Advisers' practice in relation to addressing claimants' health-related needs?

The evidence used to address research question five comes from the review presented in Chapter Five, and practice observation and in-depth interviews. Overall, there were a number of factors that were found to either support positive practice or undermine Personal Advisers' ability to support claimants with long-term conditions. Therefore, questions were raised about the quality and equity of this support.

In terms of an organisation's culture, unsurprisingly the primary research revealed there were variations. However, I was unable to explore fully or to trace whether Personal Advisers' behaviours were linked to the culture of their organisation. Therefore, any claims in relation to these factors are tentative and an area that would benefit from more investigation in the future. The primary research showed there were similarities in how Personal Advisers, across the three participating organisations, made little reference to modifying their practice in relation to meeting claimants' health-related needs in light of having to also achieve job outcomes. This is surprising given the earlier research highlighted in Chapter Five, which showed that Personal Advisers had been selective in their practice and worked with claimants who were deemed to be closer to moving into work. This new finding also contrasts with claimants' views that were expressed in my in-depth interviews. Here, some claimants described how Personal Advisers primarily focused on their work goals without acknowledging their health-related needs. However, further exploration of

these cases also shows that these claimants had involvement with more than one Personal Adviser within their programme, and that their health information may not have been passed onto their second adviser.

While all of the three participating organisations were non profit making, observations revealed that there was a clear management steer for Personal Advisers to perform and achieve their job outcome targets in two of the participating organisations. This was particularly emphasised in one organisation by the manager during team meetings. However, in both of these examples, the importance of caring for the people who participated in their programmes was indicated to be a central ethos. One of these organisations adopted the notion of '*tough love*' (see Chapter Seven). In contrast, the other organisation reported making a loss through the delivery of their programme, however, both of these organisations (from managers' and Personal Advisers' reports given in in-depth interviews) appeared to go above and beyond what was likely to be expected in their DWP contract in terms of supporting claimants' lives. In these cases an overarching caring ethos may have been more central in delivering Personal Advisers' practice than the contractual requirement of attainment of job outcomes.

Structure

In terms of structural support, only four of the 18 of the Primes' bid documents included in-house healthcare professional roles, and three of these roles had a requirement to support Personal Advisers' practice. Whilst it remains uncertain how many of these roles are available in practice, consultations with stakeholders through observation of the practice arena suggest that the total number of healthcare professionals employed within a Contract Package may be low. Hence, it is likely that some Personal Advisers might not be co-located with healthcare professionals and therefore, have limited support access to health-related support and expertise.

In practice, the primary research found that Personal Advisers were utilising support from the healthcare professionals who worked in the CMPs. These requests included asking for a second opinion about a claimant's health circumstances, or to find out alternative ways in which claimants' health-related needs could be supported. Sometimes healthcare professional expertise was sought when a Personal Adviser felt a claimant was considered to be at risk of

self-harm. This suggests that some Personal Advisers might not have been well equipped and supported by their organisation in responding to these issues.

In terms of integrating with NHS services, some Primes reported in their bid documents that they had established, or were trying to establish, partnerships with the NHS. Additionally, only a minority of the Primes proposed to explore ways of co-locating their services with local NHS provision. The observations and in-depth interviews revealed that while relationships between NHS health and Work Programme services were beginning to be explored at a management level. However, there was poor quality, or non-existent relationships at the frontline practice level with limited communication and information sharing. In these cases, a lack of collaboration could hamper Personal Advisers' ability to understand a claimant's health circumstances fully. Furthermore, some Personal Advisers struggled to navigate and understand the health service landscape which then became an obstacle to supporting claimants. In contrast, another organisation's manager was observed to be proactive in helping Personal Advisers to build networks with local health services. This shows the variations in whether organisations recognised the importance and value of assisting Personal Advisers to develop networks with health-related services, in contrast to others where advisers appeared to be more self reliant.

Another factor that was indicated to hamper Personal Advisers' practice was the lack of standardisation in Primes' provision of health-related training, as not all of these offered specialist health-related training in their bid documents. The interview and observational material found that even in organisations where health-related training was intended, this did not always happen in practice. For example, in-depth interviews with healthcare professionals identified that some Personal Advisers had not received health-related training (which included details about CMPs) as planned. Two reasons given for this were, time constraints and a lack of priority given by their employer. Therefore, it is likely that in some areas Personal Advisers may not utilise CMP (as highlighted in existing evidence presented in Chapter Three), in circumstances when they are unfamiliar with the potential benefits or have not built a relationship with the staff that provide this.

Other factors that hampered Personal Advisers' practice (identified through the primary research) included time restrictions through juggling contractual administration with practice related tasks. Caseloads were described by several Personal Advisers to be larger than expected and difficult to manage, leaving limited time to personalise support and build rapport with claimants. In contrast, the analysis of secondary data sources, presented in Chapter Five, found that Personal Advisers had mixed views about high caseloads hindering their work. One explanation for these differences might be increased pressures or higher caseload numbers in the Work Programme delivery than experienced in the PtW programme. Although this cannot be confirmed in this study, some Personal Advisers reported to have a case load of 180 claimants. This is higher than evidence found in one PtW study which found Personal Advisers caseloads to initially be 30 and increase to 60 (Knight et al. 2005). Moreover, high caseload numbers are of concern because the review in Chapter Five highlighted that increased workloads could lead to Personal Advisers experiencing '*compassion fatigue*'. If this occurs in the Work Programme, Advisers might be less able to perform certain dimensions and may also be at risk of work related stress or 'burn out'. Although this issue was not explored in any detail, an interview with a manager revealed that a Personal Adviser (who also had a health condition) had been overwhelmed with claimants' health issues. This may be a beneficial area for further research.

Processes

In terms of processes, the analysis of the Work Programme bid documents suggested that Personal Advisers' practice was likely to be supported through formal organisational processes. These included initial assessments that covered claimants' health-related barriers, or health assessments undertaken by healthcare professionals. Some of these healthcare professional led assessments also appeared to address the gaps in the Work Capability Assessment (WCA), for example, by incorporating claimants' functional ability tests and job matching. Some Primes also indicated that they will provide additional training (for example, from occupational psychologists) for Personal Advisers to help them conduct initial assessments.

In contrast, the observations and in-depth interviews revealed there was a lack of formal processes for sharing claimants' health information between Personal

Advisers who worked in the same programme (both in different or the same roles) as already described. Consequently, this could hamper their practice when claimants switched Personal Adviser because their health circumstances were not necessarily then made explicit. The support that claimants then received did not necessarily take into account their health-related work needs which could undermine the success of the Work Programme.

8.4.6 Research Question Six

What strategies do claimants with long-term illness adopt in order to manage their health whilst they participate within welfare-to-work provision?

The review in Chapter Five and new empirical data from observations and in-depth interviews yielded insight into the ways in which claimants manage their health whilst engaging in an employment programme. Whilst in general this study found claimants adopted varied strategies to manage their health whilst participating in welfare-to-work provision, there were some areas of uncertainty.

Observation and in-depth interviews revealed that overall claimants adopted a range of strategies and some exerted their agency to manage their health whilst engaging in employment programmes. Four ways in which claimants sought support to manage their health were identified. These were: seeking Personal Advisers' support (which is described below); utilising an internal health-related support service; use of external support such as friends or family; and use of external health-related support. Two behaviour strategies keeping quiet (where a claimant might withhold information from a Personal Adviser or give the impression they were following their advice when they were not); or fighting their own corner (by asserting their fitness to work) were also identified.

The review work revealed variation in claimants' views about the level of health information and understanding they believed a Personal Adviser should have. The primary research found that the way in which a claimant might choose to disclose, and share their health-related circumstances was indicated to be associated with the type of understanding they had about the Personal Adviser's role. In-depth interviews with claimants revealed there were varied expectations and preferences about how Personal Advisers should respond,

and the legitimacy of this role in relation to health. Within the primary research two role perspectives were identified:

- i) That the Personal Advisers' role was for employment support only. Claimants described distinct differences between the Personal Adviser's and a healthcare professional's role.
- ii) That the Personal Adviser had a partial and legitimate role in supporting claimants' health;

The in-depth interviews also revealed that although a claimant might describe their relationship with their Personal Adviser as positive, this did not necessarily mean that they also felt they had a legitimate health-related role. However, there are unanswered questions in relation to how claimants perceived the legitimacy of the Personal Adviser's role in relation to health when they sought support after their WCA which is described below.

8.4.7 Research Question Seven

What types and variations of health-related support do claimants access from their Personal Adviser?

Evidence used to answer question seven has been taken from the review work and the primary research. On the whole, whilst considering the findings also presented in 8.6.3, this study's evidence found that claimants accessed a range of support from Personal Advisers. This support could be sought for a wide variety of issues, some of which were associated with claimants' health. In the primary research claimants were found to either solicit support from their Personal Adviser, in the form of listening, giving advice and guidance after raising an issue, or (as shown in the observations), received unsolicited advice that was initiated by a Personal Adviser in response to hearing or finding out about a claimant's health issues. Whilst in some cases, unsolicited advice may be seen to fit with policy's expectations of the Personal Adviser's role, (as shown in point 8.3.1 i.e. in exploring work related activities), it also raises a set of questions about the appropriateness and relevance of this in relation to health, especially when the competencies that have been identified to be required are considered.

An important part of the Personal Adviser's role identified in the review work, bid analysis and primary research was assessing and addressing claimants' health-

related needs for work. Both the review work and primary research revealed areas of Personal Advisers' practice that responded to supporting claimants' health. The primary research showed that this support could also relate to claimants' wider life circumstances, for example, not having money to purchase food, which could have an additional impact on their health or problems following a benefit sanction. Claimants' proactive requests for a wide range of support revealed the complex nature and their expected scope of the Personal Advisers' role. Personal Advisers' support appears to have been quite central to a few claimants' lives. The in-depth interviews showed that some claimants described their Work Programme appointments as positive and enjoyed having *'tea and chat'* with their Personal Adviser. Additionally, some claimants reported that more frequent contact would be welcomed. It is uncertain whether requests for more contact highlights any potential risks in claimants becoming dependent on their Personal Adviser and it was not possible to conclude the reasons why more support was wanted. However, the primary research showed that this might be linked to: a strong desire to move into work (this was corroborated in previous research as shown in Chapter One); having limited, or no other forms of support networks; or associations with establishing a routine (which was noted to be important to some claimants especially those with mental health needs via in-depth interviews) and opportunity to get out of the house whilst having their transport costs reimbursed. Although many of the claimants who took part in the primary research had involvement with NHS services (especially GPs), these findings imply that other forms of support are likely to be important. It also implies that claimants' needs might not be being fulfilled by other services. Therefore, this suggests that some claimants might be reliant on seeking Personal Advisers' support.

8.4.8 Research Question Eight

What strategies do Personal Advisers adopt within their practice involving claimants with health-related needs?

Insight into the strategies adopted by Personal Advisers came from the review work presented in Chapter Five, the analysis of the Work Programme bid documents and the observations and in-depth interviews with Personal Advisers presented in Chapter Seven. Overall, Personal Advisers were found to have considerable autonomy and discretion in their practice in how they responded to claimants' health-related needs in the organisations where I conducted

interviews and observational work. This was also consistent with the findings identified within the Work Programme bid documents and the review conducted for Chapter Five. This is not surprising given the relatively marginal position of health in this area of practice within the Work Programme as shown in research question one in point 8. 3.1. The evidence from the new empirical and realist review work found that in general Personal Advisers are likely to draw on and adopt a broad range of strategies in their day to day practice to support claimants with health-related needs.

Building a collaborative relationship with a claimant was a core feature of the Personal Adviser's role that was identified in Chapter Five. Similarly, the importance of this relationship was evident to some extent in the Work Programme bid documents which often (though not always) outlined continuity of a Personal Adviser role and in the primary research. Additionally, the primary research revealed that Personal Advisers adopted four different behavioural styles in their interactions with claimants. These four styles were: tough love, collaborative, supportive and informal and could be employed to assist in building relationships. Combinations of these behavioural styles were also observed to be used during Personal Advisers' interactions with claimants and in some cases these styles were purposefully selected.

Gaining a better understanding about claimants' health conditions was a key practice task that was identified in the review work, Work Programme bid analysis and primary research. The primary research showed that in general Personal Advisers adopted a range of strategies to fulfil this task which included: seeking more health information from reports or healthcare professionals; drawing on their own or others (including past claimants) illness experiences; and searching for medical information for example, on the internet. While similar findings were found in the review work presented in Chapter Five, this evidence also found that some healthcare professionals gave conflicting advice about a claimant's capability for work and this made Personal Advisers' interactions difficult. These difficulties were not expressed by Personal Advisers during my observations or in-depth interviews. However, claimants raised concerns about received 'mixed messages' about their fitness to work as discussed below. Observations illustrated that some Personal Advisers make their own judgement about a claimant's health condition and fitness to work,

(particularly when responding to issues concerning a WCA appeal) without seeking healthcare professionals' input. In these situations, Personal Advisers were found to foreground claimants' illness or fitness in their interactions. Consequently, some claimants received 'mixed messages' about their fitness to work. This is an important area to consider given some claimants who were interviewed expressed concerns about receiving mixed messages and felt a need to exert a right to receive support and work by 'fighting their own corner'. Conversely, this practice may also push a claimant further away from employment if an illness perspective is driven inappropriately.

Further evidence presented in Chapter Five and Seven shows that Personal Advisers exercised personal judgement, at times disregarding formal organisational processes and procedures. The primary research revealed that some Personal Advisers' practice remained hidden or were unknown by their manager. This is another finding that concurs with Lipsky's (1980) observations of frontline workers' autonomous practice. This was consistent with the findings in the realist review work, which illustrated the autonomous nature of this role when Personal Advisers choose to purposefully ignore managers' directives; for example, where organisational categorisation systems were used to determine claimants' readiness to work and prioritise whom they should be helping first.

8.4.9 Research Question Nine

What competencies does a Personal Adviser need to support their ways of working with claimants who have health-related needs?

The evidence used to answer question nine has been drawn from all elements of the study. In answering this question the notion of competencies reflects the current context of the Work Programme policy in which Personal Advisers have been found to have a wide range of discretion in their practice. While the role of the Personal Adviser seems sensible and viable, claimants' health needs appear to have been sidelined to some extent within policy. Therefore, some Personal Advisers reported they had limited access to health-related provision or healthcare professionals' expertise. Limited integration between the NHS and Work Programme provider organisations was indicated in the bid documents, consultations with stakeholders and in-depth interviews with Work Programme managers. This suggests that unless there is a clear steer and commitment at policy level to adopt a more central health focused approach to help claimants move into work, Personal Advisers will require a higher level of

competencies. Additionally, changes in Work Programme organisational structures and processes to help Personal Advisers perform their role successfully will also be required.

The Personal Adviser's role was found to be multidimensional in the review of secondary data sources, presented in Chapter Five. Here, eight role dimensions that that Personal Advisers might adopt that related to health were identified. These dimensions were: assessor, counsellor, gatekeeper, enforcer, enabler, navigator, seller, and advocate. Some of these eight roles were mentioned in the bid documents, for example, assessor, enabler and enforcer. All of these eight roles were evident to some extent in my observations and in-depth interviews across three organisations.

Two additional role dimensions: health promoter (for example, giving health-related advice) and health monitor (for example, in checking claimants' health, which included any risk of self-harm while on "*suicide watch*" and when people were identified as "*wobbling*" after starting work) were identified through observation of the practice arena and in-depth interviews. These two new roles were corroborated through the wider ethnographic work which involved informal interviews with Personal Advisers and programme managers from other employment programmes such as Jobcentre plus (JCP).

Thus, within the current policy context the findings suggest that Personal Advisers are likely to require the following seven key competencies which relate to how they respond to, and support claimants' health needs in relation to work:

- To be able to recognise the boundaries of their role in relation to responding to claimants' health-related needs.
- To have an adequate understanding of the potential impact of claimants' health-related needs in relation to work.
- To be aware of their own views about 'fitness for work' and how these might influence their practice.
- To understand what health-related support might be of benefit in relation to work and know who is who, and who does what, in health related services.
- To understand and mobilise the referral pathways to health-related support services.

- To know how to 'sell' and encourage claimants to consider participating in a health-related support intervention.

In the absence of having a clearly defined health-related role boundary, the realist review work and new primary research revealed there is a risk for Personal Advisers to engage in activities that are more typically associated with a healthcare professional, or to over-stretch their role when trying to do their best and 'care' for a claimant. Most of the Personal Advisers who took part in this study talked about, or were observed to work with, people who had a wide range of health conditions. Some of these conditions appeared to be uncommon or poorly understood. Additionally, as some claimants had fluctuating health conditions there were times when it was important or essential that they received healthcare professionals' support. Some Personal Advisers appeared more able to help make this possible than others. Evidence reviewed in Chapter Five, and the new primary research, showed that Personal Advisers had a varied knowledge base and confidence about health conditions. This information has been shown to be important to support assessments and how Personal Advisers' address and help to problem solve claimants' health-related barriers to work.

Observations revealed that it was common for Personal Advisers to respond to claimants who sought guidance about their WCA or appeals. Similar findings were identified in the review work in Chapter Five. This included providing support for claimants who reported they were unhappy with a 'fit for work' decision, or who were trying to come to terms with being found fit for work. Overall, Personal Advisers had varied approaches to addressing this. The review work in Chapter Five highlighted Personal Advisers' adoption of an advocate role in some of these circumstances. The primary research supported these findings and also revealed that Personal Advisers might adopt illness or fitness perspectives based on their personal judgement in the absence of any medical supporting information.

The primary research further highlighted that Personal Advisers needed, at times, to be able to respond to challenging situations which involved claimants' safeguarding issues. Although one of the observed organisations was found to have clear safeguarding procedures, the in-depth interviews highlighted that

there was a lack of clarity amongst some Personal Advisers in knowing how to deal with a claimant's complex issues which included risks of self-harm. In these situations, Personal Advisers need to be aware of how to respond, the limits of the support they can offer, and the scope of their practice.

The primary research also showed that identifying and responding to claimants' health-related barriers often required Personal Advisers to liaise with external agencies and other professionals. However, Personal Advisers reported in interviews that this support was not always achievable. In these circumstances, Personal Advisers needed to be able to respond creatively, and be resourceful in seeking solutions to a wide range of problems that claimants sought support for. Being able to navigate local health-related provision effectively and know who is who, and what was available was therefore important for many Personal Advisers. Personal Advisers need to be able to confidently 'sell' any associated benefits to encourage claimants' participation. This skill was highlighted in Chapter Five as well as in the previous evidence presented in Chapter Three.

8.5 Conclusion

This chapter has revisited the theoretical framework and identified where this study's findings differ, concur or extend Lipsky's (1980) theory. It has evaluated the strengths and limitations of this study's methodology and methods adopted. It has outlined the advantages of adopting a multilayered ethnographic approach which utilised a wide range of data sources. These sources examined the macro, meso and micro-level factors that related to the nine research questions. The findings from Chapters Five, Six and Seven have been integrated. This synthesis has provided a more comprehensive picture of the extent to which: claimants' health needs have been framed within policy; how policy has been interpreted by provider organisations and operationalized in Personal Advisers' practice at the frontline. Key themes that have emerged in relation to the availability of health-related support within the Work Programme concern the variability and patchiness. This raises concerns about equity of access and the adequacy of provision for claimants. The theoretical claims have revealed the complex nature of the multidimensional role of the Personal Advisers and expected scope of practice in relation to health which is likely to be found in similar employment support services. Personal Advisers have been shown to have considerable autonomy and discretion in their day to day

practice when working with claimants who have long-term conditions. This is of concern given that their role boundaries in relation to health have yet to be clearly defined. There is strong evidence of patchy provision of training and support. These issues are explored in the final chapter which draws out the key themes that have emerged in relation to supporting claimants' health. Chapter Nine also discusses the implications of the findings in relation to policy, practice and further research.

Chapter Nine: Discussion and conclusions

9.1 Introduction

This chapter aims to summarise the main messages from this study to show why they are important, identify what is new knowledge and to draw conclusions. It identifies key themes that have raised a number of issues and questions about the way in which claimants' health-related needs are responded to within welfare reform policy. These themes relate to the Work Programme's black box approach, the Personal Adviser's role and health-related support provision and are discussed in relation to the five research objectives that were outlined in Chapter Four. These themes are of importance in relation to the Government achieving its aim of personalising support to prepare claimants with health-related needs to move into sustainable employment. The emerging Work Programme evidence reviewed in Chapter Three and the set of risks and assumptions concerning the Work Programme policy that I highlighted in Chapter Six are also revisited in light of this study's findings. Recent literature concerning the Work Programme's delivery and emerging developments about the Personal Adviser's role are also considered.

The study's objectives were:

1. To identify how welfare reform policy, particularly the Work Programme aims to reduce the numbers of people with long-term illness who are claiming out of work benefits and to help them make progress into paid work.
2. To examine in detail how and in what ways the Work Programme is framed in particular in providing health-related support provision.
3. To explore how Work Programme provider organisations interpret and operationalize welfare reform policy objectives within their delivery models.
4. To examine the role of the welfare-to-work Personal Adviser and identify the ways in which their practice supports or hampers claimants with long-term illness to manage their health whilst progressing towards paid work.

5. To explore whether and how claimants with health conditions experience support for their health-related needs from their welfare-to-work Personal Adviser.

This chapter has five sections. The first section (9.2) covers research objectives one, two and three and discusses five key themes in relation to the Work Programmes' black box policy approach and support for claimants with health conditions. The second section (9.3) concerns research objective four, and discusses three themes that relate to Personal Advisers' practice. The third section (9.4) considers research objective five, and claimants' experience of Personal Advisers' support in relation to policy's personalisation agenda. The fourth section (9.5) outlines the potential implications for policy, practice and future research that have been raised. The fifth section (9.6) outlines my dissemination activities. The chapter concludes by restating the study's contribution to knowledge and the key messages that have been identified in this study.

9.2 Research objectives 1-3

As discussed in Chapter Eight, the overarching aim of the Work Programme policy is to provide tailored support to ensure people move into sustainable work. In relation to responding to claimants' health-related needs the Government has assumed that the black box approach will '*...lead to providers developing new ways to support people with health conditions at work*' (Freud 2011b), and that innovation will be made possible through the payment by results model. Furthermore, differential payments are assumed to prevent provider organisations being selective in their practice i.e. "cherry picking" claimants deemed closer to securing work.

The study's findings have indicated a number of benefits and drawbacks of the black box approach currently adopted by UK welfare-to-work policy. This section discusses five key themes that relate to this approach. These are: varied levels and models of health-related support; the importance of the Personal Adviser role; payment models and associated costs of health-related support; innovation; and integration between health and welfare-to-work.

Varied levels and models of health-related support

This study's findings found that through the adoption of the black box approach, Primes were given considerable leeway in designing their delivery both generally, and in relation to how claimants' health-related needs are addressed. This is important because this level of freedom has subsequently been shown to lead to varied proposed levels and models of investment in different types of health-related support provision. This indicates that some claimants' health-related needs may be better identified and addressed by Work Programme provider organisations than others. Therefore, some claimants may be more prepared to move into and sustain work than others. Additionally, Primes have been found to give varied prominence to health issues, especially in terms of whether health-related support has a health, work or integrated health-and-work focus. Moreover, the lack of prominence given to explicitly addressing claimants' health in the 18 different Primes' minimum service levels (now more commonly referred to as minimum service standards) raise concerns about claimants with health-related needs ability to have equal access to any provision and whether the support offered will adequately address their health-related needs. However, these standards were difficult to evaluate given their variations. This is an issue that has been debated in the recent House of Commons and Pensions Committee's (2013) report titled: '*Can the Work Programme work for all user groups?*' This report questioned whether these standards can be monitored adequately, and whether there should be standardisation. While a response by a representative from the Employment Related Service Association (ERSA) reveals concerns that standardisation could jeopardize Personal Advisers' ability to tailor support (Hughes 2013), these findings suggest that the DWP should review the effectiveness of these standards.

Overall, analysis of the Primes' bids implied there would be more reliance on health-related support provision being delivered by external specialist subcontractors or selected organisations on an ad hoc basis than in-house. Newton et al.'s (2012) preliminary evaluation of the Work Programme, (discussed in Chapter Three) documented varied use of specialist provider organisations or spot purchase, with reports of frequent or no use. Limited use of specialist subcontractors was also found in Kerr's (2013) research. Moreover, the National Council for Voluntary Sector Organisations (2012)

revealed the initial concerns raised by some provider organisations within the voluntary sector who reported receiving few, or no referrals from the Work Programme, which was not what was expected. Whilst these three studies did not explicitly examine health-related support provision, these findings suggest that some claimants may not be able to access the health-related support provision that was outlined in the bid documents. Furthermore, within the Work Programme evaluation there were no reports of in-house healthcare professional roles (Newton et al. 2012), a finding that resonates with my new finding that indicated there would be limited use of such roles. Therefore, there is uncertainty in whether the Primes' proposed models of health-related support are coming to fruition. Furthermore the current provision may be inadequate to meet demand, risking 'parking' practice. Therefore, it may be difficult for some claimants to access health-related support.

Importance of the Personal Adviser role

The importance of the Personal Adviser role in the delivery of employment support has been emphasised in both policy and Work Programme bid documents. As discussed in Chapters Three and Six, there have been, and are high expectations for a Personal Adviser role in assessing and addressing claimants' health-related needs with a focus on both "enabling" and "enforcing". As an enabler, a Personal Adviser is expected to personalise support while at the same time retain an enforcer role (with increased powers and responsibility) to ensure claimants adhere to conditionality measures. Additionally, it has been assumed that people employed as Personal Advisers will be both willing and competent to implement policy's objectives. The importance of the Personal Adviser role is further emphasised when examining claimants' access to health-related support. Access within the Work Programme appears to be heavily dependent on an organisations' assessment process, which is often undertaken by Personal Advisers, as shown in Chapter Six. At the same time, questions have been raised by the current research about Personal Advisers' competencies and how they are prepared and equipped to fulfil their role which is discussed below.

Payment models and associated costs of health-related support

Government has assumed that provider organisations would be incentivised to provide health-related support because of the '*larger fees*' associated with

moving 'harder to help' groups into work (Freud 2011b). However, this study revealed that the associated costs in providing, both internal (in-house) and external (e.g. specialist subcontractor), health-related provision was a challenge for provider organisations. These findings chime with Newton et al.'s (2012) study which documented advisers' reports of cost restrictions limiting their access to health-related support provision. Therefore in these cases, advisers were more reliant on in-house support, or in helping claimants to access external support, which was essentially free (Newton et al. 2012). This suggests that claimants' receipt of health-related support (through specialist providers) is likely to be variable and patchy. This is an important finding because it questions whether Primes are effectively incentivised to offer health-related support and/or able to sustain the costs of not only providing this, but willing to create innovative services. It also indicates there may be additional demand for NHS e.g. GPs, Improving Access to Psychological Therapies or third sector services. Newton et al.'s (2012) study also raises concerns about whether there may be any intentional rationing of Primes' proposed health-related provision (i.e. specialist subcontractors or spot purchase) because of associated costs. Similarly, there are queries about whether claimants' health needs are being marginalised, because support has been prioritised for people deemed to be closer to returning to work (Newton et al. 2012). However, it is difficult to draw conclusions because there has been minimal investigation of the Work Programmes' health-related support provision to examine claimants' access to-date.

The effectiveness of the Work Programmes' differential pricing model has also been criticised by some Work Programme provider organisations (Shaw Trust and CDG 2013, G4S 2013). Two of these organisations have reported that the current pricing model needs to be reviewed to reflect claimants' progress i.e. their distance travelled and not to be associated with a benefit type but on individuals' needs (Shaw Trust and CDG 2013). Shaw Trust and CDG (2013) have also recommended that some claimants in the Work Programme with severe needs, could be supported better in Work Choice (Shaw Trust and CDG 2013). This recommendation implies that the levels of support required by some Work Programme clients cannot be currently met by existing provision.

These latest findings confirm and extend my study's findings and suggest there are limitations in the current Work Programme delivery in providing adequate support for claimants with health-related needs. If health-related support is not made accessible, my findings indicated that Personal Advisers might attempt to respond to claimants' needs themselves, or unwillingly adopt "parking" practice. This is an important new finding because the empirical research has also shown that some Personal Advisers have struggled or not been competent to respond to claimants' health-related needs, therefore the Government's aim to ensure that the Work Programme is supporting 'harder to help' groups may not be being fully realised.

Innovation

On the more positive side, a black box approach might encourage innovation. When comparing the limitations of the PtW CMP, that were highlighted in Chapter Three, there seem to be a number of improvements, for example, with the introduction of three in-house healthcare professionals' roles which aim to support Personal Advisers' practice. There is also a stronger emphasis on work focused health-related support, illustrated by the provision of post work support in the form of telephone support interventions. However, my primary research revealed there was minimal focus on in-work health-related support in two provider organisations who delivered a CMP. Although this lack of focus might be explained because the Work Programme was in its infancy when this study was conducted, and therefore, less people may have moved into work that required this support, it nevertheless deserves further investigation. This is a crucial new finding because people with health conditions have been found to struggle to sustain employment if they experience difficulties in relation to their health that are not supported in the work place (Black and Frost 2011). Therefore, any lack of in work support may compromise claimants' sustainability in work. This undermines the goals of the Work Programme policy and also risks provider organisations' receipt of payments for claimants' sustainment in work.

It is speculated that the proposed telephone interventions (mentioned above) might be cheaper to deliver than face-to-face interventions. In addition, they may have the added advantage of being easier to access for some claimants, and may eliminate some of the provider organisation's' associated costs, such

as hiring venues, or paying for claimants' travel. The evidence presented in Chapter Three revealed that (in one study) CMP CBT type telephone interventions (Demou, Gibson and MacDonald 2012) were effective for some of the claimants who participated. A recent literature review has shown that telephonic interventions can be both effective and cost effective (Burton et al. 2013). However, the additional benefits that claimants have been found to experience through group interventions, for example, gaining peer support (Macmillan Cancer Support 2010) might be missed if only telephone interventions are used. Nevertheless, given that provider organisations have expressed cost concerns, and there have been restrictions in Personal Advisers being able to access health-related support (Newton et al. 2012), in addition to, a lack of familiarity in employing healthcare professionals, as discussed in Chapter Eight, these newer telephone models appear worthy of further investigation to determine their acceptability, effectiveness and cost effectiveness.

~~Integration between health and welfare-to-work~~

Governments' aspiration to improve the integration between health and welfare-to-work services is not new, as highlighted in the policy review in Chapter Three. The Government were noted to assume that the black box approach '*... encourages Work Programme providers to form partnerships with other organisations such as local authorities, [and] health service providers....*' (DWP 2011a, p9) in Chapter Six. This reveals high expectations for this approach to lead to 'buy in' and mutual agreements between both Work Programme provider organisations and the NHS. This contrasts sharply to the PtW programme where the Department of Health and the NHS had a clearly defined role that was financed in agreement with the DWP as described in Chapter Three.

My analysis (presented in Chapter Six) indicated there might be feasibility concerns for Work Programme provider organisations in establishing NHS partnerships, as these could take time, and that there might be disagreements and a lack of clarity over who should pay for claimants' health interventions. This study found there were varied levels of proposed or actual engagement taking place between Work Programme provider organisations and the NHS. In practice, integration was low, and where developments were taking place these were at a strategic level and tentative, rather than carrying through to frontline

practice so far. This is an important new finding because a lack of integration at the frontline was subsequently found to limit Personal Advisers' practice in supporting claimants with health-related needs. Therefore, claimants' health-related barriers to employment were at risk of not being addressed. This may limit their chances of gaining work that again undermines the aims of the Work Programme policy.

The Government expected that larger payments would incentivise Work Programme provider organisations to assist people who are considered as 'harder to help', for any success. This expectation has fostered a feeling amongst some NHS stakeholders that health-related support provision is the responsibility of the Work Programme provider organisations, and therefore, these organisations should provide the funding. These views and a lack of clarity in roles are likely to make integration more difficult. Moreover, as the implementation of the Work Programme coincided with changes in NHS configurations and growing demands on the NHS this is likely to have made the task of integration even more challenging. This study also revealed a lack of recognition by NHS stakeholders about the associated health impacts that the welfare reforms were shown to have in this study on claimants' health, for example, lack of money for basic necessities including food, which Work Programme provider organisations were found to be addressing. These new findings raise questions about whether it is appropriate for Work Programme provider organisations to provide general health support for claimants that is unrelated to work, and to also 'foot the bill'. In addition, it highlights the variations and diversity of health-related support that claimants need, or seek, and how these needs are perceived differently by varied stakeholders. Moreover, these new findings have raised crucial questions about the nature of the 'black box' policy approach and whether this is capable of delivering as expected. The issues raised, especially in terms of ensuring claimants' equitable access to health-related provision, and standards of frontline workers' practice may have wider implications for further reforms if the Government intends to extend the black box approach and contracts to other areas of public provision.

9.3 Research objective 4

This section discusses the role of the Personal Adviser and how their practice has been shown to be supported or hampered when working with claimants who have health-related needs. Three key themes explored are: training and competency; agency; and legitimacy and clarity of their health-related role. Typically, the Personal Adviser's role has a central and essential place in the Work Programme's delivery across the Primes, but it is not standardised across the welfare-to-work industry. Some of the Personal Advisers' roles have been documented by Work Programme provider organisations to be specialist and more focused on addressing claimants' health issues than others.

Training and competency

Overall, this study found that Personal Advisers were likely to have varied levels of training and competencies in being prepared and equipped to support claimants' with health conditions. This finding is of importance, because a lack of knowledge in health was associated with Personal Advisers' inability to help some claimants make progress into work. The Work Programme provider organisations' offers of health-related training varied, with some organisations paying more attention to this area of practice than others. In this study, Personal Advisers were aware of what additional training might be of assistance to support their work. This finding concurred with other empirical evidence as shown in Chapter Five for example, McNeil (2009). The training Personal Advisers desired included more knowledge of mental health conditions, and improving their skills in navigating the health system provision. However, it is unknown if this training would be made available by their employer. These needs also suggest further value in improving integration between the NHS and Work Programme provider organisations as some of these needs could potentially be met through collaboration.

Chapter Three showed that policy proposed to support Personal Advisers' practice through the provision of medical related information (the work focused health related assessment (WFHRA) element of the WCA), and training. Recommendations to improve the WCA to inform Personal Advisers' practice were a recurring theme in the policy documents reviewed in Chapter Three. However, within this study it was not uncommon for Personal Advisers to

receive limited medical related information to support their work. Therefore, there is a disjuncture with the Government's recent decision to continue to suspend the WFHRA element of the WCA until 2016 (House of Commons Work and Pensions Committee 2013). In particular, Personal Advisers' practice was found to be hampered in this study when they received limited medical related information to support their work. These findings are valuable because they also raise concerns about a Personal Adviser's competency to implement conditionality effectively, (in relation to work related activities that focus on health interventions, such as condition management) which could be hindered if claimants' health-related information is not made available to inform their decisions.

Other factors that were found to hamper Personal Advisers' practice related to obtaining medical information from services such as the NHS. Thus, in order for a Personal Adviser to identify health-related support options for claimants in these situations, it appears that there was reliance on: Personal Advisers' interpersonal skills; the nature and quality of their relationship with a claimant; the quality of Work Programme provider organisations' assessment processes; claimants' views on the legitimacy of the Personal Advisers' role in relation to health, as discussed in Chapter Eight, and claimants' willingness to share health information.

Agency

High levels of discretion and autonomy in Personal Advisers' practice, in terms the support they decided to offer claimants in relation to health, were confirmed in this study. Autonomous roles were also reflected in Newton et al.'s (2012) new findings. However, this degree of autonomy appeared to be linked to whether a Personal Adviser worked in a provider organisation that worked with claimants for their duration of participation in the Work Programme, (i.e. end to end where there was likely to be more scope to be autonomous), as opposed to a specialist or ad hoc provider organisation which had a specific remit. In this study, a high degree of autonomy and discretion appeared to encourage Personal Advisers to extend their role and support claimants in ways which at times stretched beyond their role boundary. This high level of agency and discretionary practice raises a number of issues regarding the safeguarding of claimants as well as Personal Advisers. It also reveals how claimants with

similar needs may experience a differential level of support from the same or different Personal Adviser within the same organisation. This shows the arbitrary nature of the Personal Adviser's offer that is given to claimants, role, and importance of ensuring there are more consistent standards of practice across the whole sector. This is particularly important to ensure that all claimants with a health-related barrier to work have equal chances of accessing support and moving into work that is a goal of the Work Programme policy.

Some Personal Advisers' construction of claimants' illness appeared to be associated with how they promoted a wellness or illness perspective when they interacted with claimants. This is an important finding because in this study claimants reported receiving "mixed messages" about their "fitness for work" and therefore developed behavioural strategies to deal with these. These "mixed messages" were found to be driven, reinforced or challenged by a Personal Adviser, as well as other stakeholders who were involved with claimants. Again this highlights the potential benefits in improving the integration between health and welfare-to-work provision to reduce the conflicting reports about fitness to work that claimants in this study (as well as previous research) have reported to experience.

Training and supervision that allows Personal Advisers to reflect on whether and how they focus on health issues and why may be of benefit. However, because Personal Advisers need to attain job outcomes, supervision arrangements may also need careful consideration. For example, being honest to a line manager about any challenges in working with claimants who have health conditions may prove to be difficult for some Personal Advisers. Moreover, if a line manager has no health-related knowledge or experience they may not be best suited to take on such role.

Legitimacy and clarity of role

The expectations for Personal Advisers to be able to support claimants with health conditions permeate the welfare-to-work policy and practice context. However, this study revealed new knowledge to show that there was a lack of clarity about the legitimacy of the health aspects of this role amongst Personal Advisers, as well as claimants. This study found that there was a lack of consensus amongst Personal Advisers in how they perceived their role in relation to health, and whether they had a primary work focus, partial health-

related focus, or central health-related focus. At the same time, I identified ten role dimensions that Personal Advisers adopted which related to health. Personal Advisers' engagement in some elements of these role dimensions was more akin to those of healthcare professionals. This is of concern given the issues raised in relation to Personal Advisers' training, competency and lack of defined role boundaries. Moreover, the extent to which these ten dimensions, particularly the role of health monitor, are employed by Personal Advisers in the current and future context of welfare reform (which is likely to be tougher in terms of conditionality with the introduction of Universal Credit and the claimants' commitment¹⁵ (DWP 2013c) is unknown, but appears likely to be ongoing. Thus, there are a number of policy and practice improvements that could be addressed to support Personal Advisers which are discussed below.

9.4 Research objective five

This study highlighted a wide range of ways in which claimants received support from a Personal Adviser. In relation to responding to their health-related needs, this study found that claimants experienced varied levels of support from a Personal Adviser which was either solicited or unsolicited.

Personalising support

In terms of the Government's personalisation agenda, this study found that Personal Advisers "*cared* about helping claimants improve the quality of their life and frequently tried to offer support for a wide range of needs. The positive aspects of being able to personalise their services were shown to foster creative and resourceful responses to help claimants to address their needs. In some cases where Personal Advisers were able to identify claimants' health-related needs, they were limited in being able to find, or access solutions i.e. services and interventions, (both internally and externally). Hence, claimants were described to be "*stuck in a pof* and at risk of being unsupported and *parked*' in the system. When revisiting the emerging findings about the Work Programme delivery, Newton et al.'s (2012) study was unable to confirm whether 'parking practices' were evident. However, it was apparent that claimants could be categorised and support prioritised in relation to their job readiness. This same

¹⁵A claimant commitment is made prior to receiving any benefits. This agreement is made by a Personal Adviser and details the activities that a claimant will engage in such as work preparation and job search. If a claimant fails to complete these activities without good reason they can receive a benefit sanction. A claimant commitment is being introduced to the Work Programme from autumn 2013 (DWP 2013c).

study also found that Personal Advisers' personalisation of support was generally more "*procedural*", for example, in terms of building a relationship with a claimant and conducting assessments, than "*substantive*" and responding to specific needs (Newton et al. 2012, p101). Although Newton et al.'s (2012) findings appear to resonate to some extent with my findings that were described in Chapter Seven, I also found responsive practice.

In my study, Personal Advisers reported to struggle to personalise services when they had large caseloads, for some this involved supporting up to 180 people. Similarly, high caseload numbers were reported in the House of Commons and Pensions Committee's (2013) report. This suggests that the aspiration for Personal Advisers' caseloads to be limited to 80 people, as documented in G4S' (2011) bid and as 60 people by one of the participating organisations in this study, does not appear to fit within current Work Programme reality. New research has also indicated that one-to-one claimant sessions are being compromised, when group work or telephone contacts are favoured as solutions to address the large numbers of claimants who need to be seen (Newton et al. 2012). Therefore, whilst in my study, the spirit of personalisation has been embraced as the right aspiration by Personal Advisers and managers, the current structural systems in which Personal Advisers are required to work have been shown to restrict this. This finding is of importance because it suggests that unless changes are made to reduce Personal Advisers' caseloads to increase the time they can spend with claimants and their resources of support are widened, in particular with improved integration with NHS services, there are likely to be ongoing challenges in meeting this agenda. Therefore, there is likely to be inequity and patchiness in the provision of support provided to claimants. This is a noteworthy new finding because some claimants may be underserved and experience inadequate access to health-related support provision.

9.5 Recent policy developments

At the time of writing, the Work Programme had been operational for more than two years, and some of the emerging research evidence and stakeholder discourse indicates that what was promised in terms of support in the Primes' bids is not necessarily coming to fruition (Newton et al. 2012, Kerr 2013, House of Commons and Work and Pensions Committee 2013). However, it is

important to note that there are a number of possible explanations for this. For example, one explanation for this may be linked with how the black box approach is interpreted in practice. Lane et al.'s (2013) Work Programme evaluation study (reviewed in Chapter Three) found there was a lack of clarity amongst provider organisations and DWP representatives, about how the black box principle should now be operating. Therefore, there are contrasting views as to whether there is a requirement for Primes to deliver what was set out in their bid, or continue to draw on the black box approach and be flexible to respond to claimants' needs (Lane et al. 2013). Another explanation for the limited use of specialist provider organisations was found in the views expressed by respondents in Kerr's (2013) survey. Here, some respondents talked about claimants' health needs not being properly identified in order to support a referral to a specialist provider organisation. This resonates with this study's findings which showed that Personal Advisers sometimes struggled to identify claimant's health-related needs. This is an important new finding, because it indicates there are problems with some of the Primes' assessment processes. These processes could potentially be supported through integration with health services and related professionals, in addition to improvements to the WCA as already highlighted.

Evidence also shows that the Work Programme has had limited success in terms of supporting claimants with health-related needs into work (Newton et al. 2012, House of Commons and Pensions Committee 2013, Kerr 2013). Similar views have been expressed in a report by Disability Rights UK (2013) which has also questioned the effectiveness of Work Choice. Therefore, it is perhaps unsurprising that the importance of addressing claimants' health-related needs appears to be currently in the policy "spot light". For example, the Government have reported that some Work Programme provider organisations are supporting claimants with health-related needs more than others (DWP 2013d). This has led to the development of a best practice group (DWP 2013d) which will develop a framework for sharing best practice amongst Work Programme provider organisations.

In addition, two Government initiatives have been proposed to examine how ESA claimants can be supported. The first initiative involves a two year pilot project involving ESA claimants in the work related activity group. Some of this

group will be required to see a healthcare professional (doctor, nurse or allied healthcare professional) for support, while others attend Jobcentre Plus or the Work Programme. A comparison will then be made between the support given by the healthcare professional, Jobcentre Plus and the Work Programme (DWP 2013e). When talking about this project, the Employment Minister Mark Hoban (2013) highlighted the importance of health-related support by stating that:

“Many people on sickness benefits want to work, so it’s vitally important that we give them the right help to move into a job if they are able. The help we give people at the moment tends to focus on work-related skills, but doesn’t necessarily address health problems. But by giving people regular support from doctors, occupational health nurses and therapists we can do more to help people manage or improve their conditions”.

(Employment Minister, Mark Hoban 2013).

The second initiative seeks to explore what might be of benefit once a claimant exits the Work Programme after participating for two years (DWP 2013f). This involves a two year pilot scheme where a key worker will assist claimants to access services, including health-related, to help them move into work. The approach adopted by the key worker role will follow a similar pattern to the troubled families programme (DWP 2013f). This scheme appears to be based on the premise that the majority of claimants are likely to have been helped by the Work Programme and that a remaining few will require more long-term support. However, this raises questions about Personal Advisers' abilities to personalise support for claimants in a case management type role. Although a Personal Adviser may be willing to tailor their support, this may be beyond the scope of their role because of structural constraints, their personal abilities or because a claimant does not want to accept it. In light of the current findings in this study, the key worker role in this new scheme may experience similar issues in terms of their clients' perceived legitimacy of their role in relation to health and in how they will navigate and integrate with health services.

Professionalising the Personal Adviser's role

The professionalisation agenda has advanced considerably since the initiation of my study in 2009. For example, there is now a code of conduct for Personal Advisers who are members of the Institute of Employability Professionals (IEP) and positive reports about the increase in numbers of organisations and Advisers who have joined (Faherty 2013). Progress to help Personal Advisers

develop, with the introduction of an accredited qualifications framework which has an optional module covering health as described in Chapter Three, is also evident. However, these developments remain voluntary and are dependent on organisations and Personal Advisers being willing to take part. In this study, most of the Personal Advisers and managers were unfamiliar with these developments. This suggests information about the IEP and training is not yet filtering through to all areas of practice. It is also unknown if this accredited training will adequately support the health aspects of the Personal Adviser's role that have been identified in this study. More importantly, this study's findings show there is a lack of clearly defined role boundaries within the welfare-to-work industry, scope of practice or accountability for Personal Advisers' practice that relate to claimants' health. So while these developments are welcome, the significant issues described remain to be addressed.

Implications for policy, practice and research

This section highlights the key questions and issues raised by this study's findings, and other new evidence which have implications for policy and practice. It also makes recommendations for policy, practice and further research.

Policy

A recurrent theme in this study has been the weaknesses in the relationship between health and welfare-to-work provision. As shown above, making improvements to these relationships are indicated to be important for the success of the Work Programme. In addition, there has been scarce mention about the role of the NHS in the emerging Work Programme evidence, which is surprising. Hence, three fundamental questions to ask are:

- i) Should claimants' health be the responsibility and business of the Work Programme?
- ii) Should health be the primary responsibility of the NHS?
- iii) Is there a need for policy to ensure there is dual integrated role as shown in the previous PtW policy?

This study has also identified that there is a lack of clarity about how Work Programme health-related support is defined. Currently this appears to hold different meanings to different stakeholders. Therefore, there is a need to

disentangle what might be considered health support, as opposed to work-focused health support within the context of an employment support provision. This would also need to identify the differences between claimants' health-related needs and work focused health-related needs. If achieved, these definitions are likely to make it easier to clarify whether the NHS or the Work Programme should take responsibility for providing support. In turn this may clarify who should have responsibility for funding health-related support, which in some cases may be both work and health providers.

This study has shown that the Work Programme black box policy approach may be failing to address claimants' health-related needs. It has highlighted a need to explore how Personal Advisers can be better informed about claimants' health-related barriers and related support options. This is especially relevant given the continued suspension of the WFHRA element of the WCA. Additionally, while there are ongoing developments to improve the accuracy of WCA, there appears to be a lack of coherent policy guidance for Personal Advisers on how to respond, and deal with claimants' requests for support when they appeal a "fit for work" decision. This element of the Personal Adviser's practice has in some circumstances shown to encourage the adoption of an advocate role which may be disadvantageous for the claimant, provider organisation and the overall aim of the Work programme policy. These issues seem to be compounded by a need for policy to decide who should be taking the overall responsibility for claimants' health, as already highlighted. If addressed, this may support a Personal Adviser's practice decisions and clarify how they can best support claimants who have health-related barriers. These new findings may have wider relevance and extend to elements of Jobcentre Plus' provision and their Personal Adviser roles, especially in relation to the identification of claimants' health-related barriers and accessing appropriate health-related support.

The study has also raised new concerns regarding the ethical issues relating to mandating claimants to a health-related service which need to be evaluated carefully. Although this issue was not identified to be widespread, policy needs to consider the wider impact and implications that mandating claimants might have in terms of any demand for NHS services and healthcare professionals' practice, especially if this element of Personal Advisers' practice grows. Given

that healthcare professionals need to abide by their code of conduct and gain claimants' permission to engage in interventions they are also likely to need to reflect on how they respond to this unfamiliar issue. Moreover, this study found that claimants' experience of being mandated can negatively impact on their health. As described in Chapter Seven, claimants talked about feeling stressed to overtly comply with Personal Advisers' recommendations for fear of losing their benefits. Therefore, this suggests that claimants are likely to feel similar pressures if they are enforced to attend a health-related support intervention. This implies that mandating claimants to a health-related support provision may not be an effective use of resources, for example, if claimants "go through the motions" or experience negative health impacts. In addition, if there are waiting lists for health-related support, as found in this study, and support is scarce, it may be better utilised by people who are ready and willing to take part than those who are mandated. Thus, this study has highlighted that there are current areas of policy that need to be reviewed which could improve the support that claimants with health conditions receive.

Practice

The structural constraints identified in this study suggest that provider organisations would benefit from ensuring Personal Advisers have manageable caseloads, sufficient time and internal resources, and are competent in knowing about how to access appropriate health-related support services.

Practice developments are likely to require the combined investments from both Work Programme provider organisations and the NHS. In addition, a policy commitment to integrate the health and welfare-to-work work provision and to drive collaboration at the frontline would be needed. The challenges in attending to data protection issues and claimants' consent to share information across health and work related provision would also need to be addressed. An exploration of whether and how claimants' GPs' details could be shared across services is likely to be needed, as this information is not routinely made available to Work Programme provider organisations. These practice developments might enable Personal Advisers to be better informed about claimants' health-related needs and reduce any concerns about claimants' health. In particular, these developments could aim to ensure there were

consistent safeguarding protocols across and within provider organisations, with clearer communication channels and pathways linked to health services.

Consultation with NHS vocational healthcare professional experts could support the professionalisation developments of the Personal Adviser's role, in particular, by having ongoing involvement in the accredited health-related training. Health experts could also help to explore and map the scope of Personal Advisers' practice in relation to assessing and addressing claimants' health, and what the boundaries of this support should be. These aspects are familiar territory for NHS healthcare professionals. Personal Advisers are also likely to benefit from knowing more about who is who in health, and what support can be offered. Equally, NHS healthcare professionals (especially GPs, nurses and allied healthcare professionals) are likely to benefit from being more informed about the Personal Adviser's role, to understand their value and importance of sharing information across services. If achieved, these measures may support claimants' understanding of the legitimacy of the Personal Advisers' role in relation to health and support movement towards achieving a more seamless service of support across both health and work services.

Research

This study has raised a number of questions which relate to the provision of health-related support within the Work Programme and Personal Advisers' practice. Research questions relating to the key themes in the study's findings that were not able to be fully explored were:

- To investigate whether and how any differences in a provider organisations' culture influence Personal Advisers' practice.
- To identify the prevalence of any in-house Work Programme healthcare professional roles and how they operate in practice.
- To explore Personal Advisers' understanding of claimants' illness, and whether and how their constructions of illness and fitness influence their interactions with claimants and practice decisions.
- To explore whether and how Personal Advisers' practice impacts on their health.
- To explore if and how Personal Advisers are supervised in relation to their practice judgements and decision making concerning claimants with health conditions.

- To identify the take up and effectiveness of the optional health training module that is offered to Personal Advisers within the accredited qualifications framework.

Other areas for further investigation that related to the broader welfare-to-work context and were raised by, but beyond the current scope of, this study were:

- To investigate the extent to which the current welfare reforms are negatively impacting on claimants' health.
- To map claimants' involvement in health-related provision and to identify the ways in which different stakeholders address health and work related needs.
- To map and explore the value of Personal Advisers' practice tools, such as *'The working for well-being in employment. A tool kit for advisers'* (DWP 2012) which was developed with involvement of the Work Programme. This tool was not widely known to the Personal Advisers who took part in this study.
- To investigate the experiences of claimants who have been mandated to a health-related provision.

9.6 Dissemination of the study's findings

Action has been taken to disseminate this study's findings. This has included giving presentations (some specifically designed for peer feedback) at the following events:

- Learning Event co-hosted with Sheffield Hallam University and the South Yorkshire Pathways to Work Condition Management Programme, March 2011- Sheffield- *Are Personal Advisers effective at supporting people with long term health conditions back into work?*
- A Social Policy Association sponsored event-January 2011 - *Contestation and Continuities: Health and Social Welfare in the Big Society Conference, Cardiff-Taking the back to work journey together? Personal Advisers' and claimants' views of health-related support interventions: a realist review.*

- A Social Policy Association sponsored event- September 2012- "The Hardest Hit? The implications of disability research for the Government's welfare reform agenda", Leeds- *Supporting benefit recipients' health and wellbeing: A role for the Personal Adviser?*
- A White Rose Collaboration Fund Project-June 2012 from welfare to work: linking best practice in inter-disciplinary research on employment, health and disability benefits, Sheffield- *Health related support and the Work Programme: what's on the menu?*
- Sheffield City Council- Sheffield- Good Work for Good Health-October 2012- *Health related support and the Work Programme: what's on the menu?*
- Social Policy Association Conference-July2013-Sheffield *An integrated review of health-related support provision within the UK Work Programme: what's on the menu?*

Regular presentations have also been given as part of the internal doctoral regulations at Sheffield Hallam University. Stakeholders including: claimants, CMP programme managers and practitioners were invited to attend one of these presentations. The study's findings have also been informally shared whilst engaging with a wide range of stakeholders as part of my participation in the wider welfare-to- work arena as outlined in Table 4.3. A paper on the findings presented in Chapter Six, has been accepted for a special issue in the *Social Policy and Administration Journal*: Vol. 49 No. 2 (April 2015): 'New perspectives on health, work, welfare and the labour market' which will be made available online in 2014. Other papers are in preparation. Short reports summarising the study's findings will also be provided for the participating organisations and claimants who have taken part in the study.

Conclusion

Before concluding this thesis it is important to note that whilst this study has concentrated on health, there appears to be a lack of focus within the current welfare reforms to address other factors that appear to hinder a claimant's success in securing employment. These factors include: addressing claimants' training needs and the development of new skills, in particular those that will help them not to return to a past career or compromise their health, and the

labour market conditions. The key messages from this study have shown that, there has been lesser prominence to health in the Work Programme than in earlier policy, (with limited models of health-related support). Therefore some claimants may be supported better than others. Personal Advisers were found to play an important role in helping claimants to identify and address their health-related barriers. However, Personal Advisers can struggle to achieve this due to both personal skills/behaviour and organisational contextual factors. The Work Programme payment model and the associated costs of providing health-related support have shown to be challenging for some provider organisations. Therefore, they may not be able to support or sustain these. Innovation of health-related support has been shown to be mixed, with some promising types of support indicated. Finally, the integration between health and welfare-to-work services was found to be limited.

Therefore, the need for welfare policy to ensure it has a health focus has been shown to be crucial and integration between the NHS and employment provision needs to be improved, especially at the frontline. Work and Health services should not be seen as separate entities. If achieved, this is likely to be of benefit to all stakeholders. Importantly, such integration has the potential to promote a more seamless service for claimants. It may also ensure that claimants receive consistent messages about their ability to work and receive the most appropriate type of support to enable progression into sustainable work. This study has contributed new knowledge about the nature of health-related support within the policy and practice context, the legitimacy of the Personal Adviser's role in supporting claimants with health conditions and a typology of claimant behavioural strategies in the newly emerging world of welfare-to-work. It has raised important implications for policy and practice, and a number of questions that are unresolved that warrant further investigation. Finally, this thesis has found that the Personal Adviser is often at the heart of employment support delivery, being expected to be competent in adopting different roles, some of which might conflict and cause tensions, when meeting the diverse needs of claimants who have long-term illness. The majority of the Personal Advisers involved in this study were found to be passionate and caring about their work. Many claimants were also found to have a strong desire to

work. Thus, there is a need to find effective approaches to supporting Personal Advisers' practice with claimants who have work focused health-related needs.

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Appendices

Report	Authors/ year	CMP delivery	Method/data	Themes: benefits	Themes: drawbacks
Incapacity Benefit Reforms Pilot: Findings from the second cohort in a longitudinal panel of clients.	Corden and Nice (2006a).	NHS-led.	Qualitative: Interviews with 53 claimants face-to-face and then by telephone. 34 participants took part in all three interviews.	<u>Delivery:</u> Personal Advisers' encouragement to attend CMP was influential in some claimants' decisions to take part.	if their condition was 'too serious' (p112). <u>Delivery:</u> Some claimants were interested in CMP, but did not access this. Some claimants were unable to continue CMP after their IB benefit was withdrawn following a medical assessment.
Pathways to Work – extension to some existing customers Early findings from qualitative Research.	Barnes and Hudson (2006a).	NHS-led.	Qualitative: 5 interviews with claimants, 13 claimants in focus groups, 19 telephone interviews with Personal Advisers covering 17 JCP locations.	<u>Delivery:</u> CMP practitioners supported Personal Advisers when they were working with claimants who had severe mental health needs.	<u>Delivery:</u> Some claimants had no knowledge of CMP.
Pathways to Work: Qualitative research on the Condition Management Programme.	Barnes and Hudson (2006b).	NHS-led.	Qualitative: 37 in-depth interviews (face- to-face and telephone) with Condition Management Practitioners and coordinators and managers within the seven PtW pilot areas.	<u>Delivery:</u> Co-location of CMP staff within JCP sites helped to increase CMP referral rates. Communication between these two services was then improved. Some support was found to be provided for claimants who had more serious	<u>Delivery:</u> CMP staff did not necessarily view work outcomes as a short term goal, and valued improvements in claimants' health.

Report	Authors/ year	CMP delivery	Method/data	Themes: benefits	Themes: drawbacks
Pathways to work: findings from the final cohort in a qualitative longitudinal. panel of incapacity benefit recipients.	Corden and Nice (2006b).	NHS-led.	Qualitative: 28 interviews with claimants and 18 of these were followed through for nine months or more.	mental health needs. <u>Delivery:</u> Personal Advisers had a pivotal role in helping claimants decide whether to take part in CMP.	<u>Delivery:</u> Limited take up of CMP. Some claimants had health-related concerns about taking part in CMP.
Pathways to Work: Extension to existing customers (matched case study).	Dixon, Mitchell and Dickens (2007).	NHS-led.	Qualitative: Observation of 17 Work Focused Interviews, 13 follow up interviews with Personal Advisers and 17 claimants.	<u>Delivery:</u> Some Personal Advisers wanted to be more integrated with healthcare professionals.	<u>Delivery:</u> Personal Advisers had concerns about their level of health knowledge and ability to make appropriate referrals to CMP. Some Personal Advisers asked claimants to see their GP first and this then limited claimants' confidence in their Personal Advisers' ability.
Pathways to Work: customer experience and outcomes Findings from a survey of new and repeat incapacity benefits customers in the first seven pilot areas.	Bailey et al. (2007).	NHS-led.	Quantitative: Face-to-face survey with 3,507 claimants. 398 claimants involved in CMP.	<u>Delivery:</u> Nine factors were associated with the take up of CMP. (One factor included more attendance at Work Focused Interviews).	<u>Outcome:</u> 31% of claimants wanted more support from their CMP. 9% felt CMP was of little benefit. (This figure also included those who had minimal engagement with CMP).
Qualitative research exploring the Pathways to Work sanctions regime.	Mitchell and Woodfield (2008).	NHS-led.	Qualitative: 34 in-depth interviews with claimants.	<u>Outcomes:</u> One claimant who had been sanctioned found a CMP counselling session helpful.	<u>Delivery:</u> Claimants' perceptions of CMP's usefulness and quality influenced their

Report	Authors/ year	CMP delivery	Method/data	Themes: benefits	Themes: drawbacks
Pathways to Work: the experiences of existing customers Findings from a survey of existing incapacity benefit customers in the first seven pilot areas.	Hales et al. (2008).	NHS-led.	Quantitative: Survey: face-to-face 2,207 claimants across the seven PtW pilot areas. 495 CMP participants.	<u>Outcomes:</u> Participants who found CMP useful were also associated with not wanting more support after programme completion. CMP was more highly rated if a claimant's health had also shown some improvement.	<u>Delivery:</u> More support was wanted from one third of CMP participants (additional support included counselling and physiotherapy).
Pathways to Work from incapacity benefits: A study of referral practices and liaison between Jobcentre Plus advisers and service providers.	Nice, Irvine and Sainsbury (2009).	NHS-led.	Qualitative: 4 focus groups with 20 Personal Advisers, interviews with 8 Disability Advisers and 20 frontline staff.	<u>Outcomes:</u> CMP was viewed as a 'positive programme for many people' (p23).	<u>Delivery:</u> Personal Advisers had varied approaches to remaining in contact with claimants whilst they engaged and completed CMP.
A qualitative study of the customer views and experiences of the	Warrener, Graham and Arthur	NHS-led.	Qualitative: 30 in-depth participants from three Jobcentre Plus districts.	<u>Outcomes:</u> Claimants' experiences were generally positive. Varied	<u>Outcomes:</u> Claimants with physical conditions were more likely to be less

Report	Authors/ year	CMP delivery	Method/data	Themes: benefits	Themes: drawbacks
Condition Management Programme in Jobcentre Plus Pathways to Work.	(2009).			claimant experiences as to whether CMP had a direct, indirect or no work focus.	positive about CMP than those with mental health conditions.
Pathways to Work: the longer term existing customers Findings from a survey of 4-7 year incapacity benefit customers in the first seven pilot areas.	Sejersen, Hayllar and Wood (2009).	NHS-led.	Quantitative: Face-to-face survey with 2,207 claimants (year 1-3) and 1,692 (year 4-7).	<u>Delivery:</u> Claimants' increased participation in Work Focused Interviews was associated with increased CMP take up. <u>Outcomes:</u> CMP was more likely to be used by people with mental health conditions than other health conditions. Generally positive views about CMP.	<u>Outcomes:</u> 22% of CMP participants wanted more interventions for their health after completing CMP. CMP participation was not 'significantly associated with paid work' (p66).
Provider-led Pathways: Experiences and views of early implementation.	Nice, Davidson and Sainsbury (2009).	Non-NHS led.	Qualitative: In-depth interviews one-to-one and group with 30 claimants, 38 provider organisation staff: Personal Advisers, managers and 46 DWP and JCP staff: managers, third party managers and frontline staff.	<u>Delivery:</u> Personal Advisers' views about CMP varied. Some Personal Advisers felt it was a 'key intervention' (p52). CMP referrals were considered to improve when referral targets were set for Personal Advisers.	<u>Delivery:</u> One manager reported that some Personal Advisers felt that the CMP was not sufficiently work focused and therefore, questioned its value.
People with mental health conditions and Pathways to Work.	Hudson, et al. (2009).	NHS and non-NHS on led	Qualitative: In-depth interviews with 44 claimants and 28	<u>Outcomes:</u> Generally positive views of CMP reported by claimants.	<u>Delivery:</u> Some CMP staff would not provide CMP for claimants who were already

Report	Authors/ year	CMP delivery	Method/data	Themes: benefits	Themes: drawbacks
Provider-led Pathways: experiences and views of implementation in phase 2 districts	Tennant, Kotecha and Rahim (2010).	Non-NHS led.	Qualitative: In-depth interviews face-to-face with 36 claimants, 42 provider organisational led personal Advisers, 8 provider organisational led managers 6 third party managers and 24 Personal Advisers in JCP.	<u>Delivery:</u> Generally the relationships between CMP and provider organisations were good. Working in physical proximity helped.	<u>Themes: drawbacks</u> accessing NHS services. Limited numbers of claimants had experience of CMP. <u>Delivery:</u> Some claimants felt that CMP staff had limited awareness of work and health issues. Some claimants felt there was limited support for specific health conditions. Limited 1:1 sessions and short duration of counselling sessions was an issue for some claimants.
Provider-led Pathways: experiences and views of Condition Management Programmes.	Nice and Davidson (2010).	Non-NHS led.	Qualitative: Interviews with 15 Personal Advisers, 14 Condition management practitioners, 36 participants of the CMP and 10 managers who monitor the CMP.	<u>Delivery:</u> If CMP staff were co-located with provider organisations' staff, this could support the referral process, and improve Personal Advisers' health knowledge. Claimants experienced improvements in their confidence, self- management of their condition and readiness for work.	<u>Delivery:</u> CMP staff recruitment and retention issues. Staff turnover could affect claimants' progress. <u>Outcomes:</u> Some claimants experienced no positive benefits or a worsening of their health (depression) through participating in CMP.

Report	Authors/ year	CMP delivery	Method/data	Themes: benefits	Themes: drawbacks
The influence of outcome-based contracting on Provider-led Pathways to Work.	Hudson, et al. (2010).	Non-NHS led.	Qualitative: Interviews with 24 Personal Advisers, 4 managers and 14 subcontractors and partners. Covered four delivery areas.	<u>Delivery:</u> Varied CMP delivery models identified in-house and subcontracted.	Not identified in relation to CMP.
Pathways to Work: The experiences of new and repeat customers in Jobcentre Plus expansion areas.	Hayllar, Sejersen and Wood (2010).	NHS-led.	Quantitative: Face-to-face survey involving 2,679 new and repeat claimants in expansion areas and 3,507 new and repeat in pilot areas. 430 claimants were involved in CMP.	<u>Delivery:</u> 51% of the participants gave high rated scores about CMP.	<u>Delivery:</u> Some JCP districts had more up take of CMP than others.
Provider-led Pathways to Work: the experiences of new and repeat customers in phase one areas.	Hayllar and Wood (2011).	Non-NHS led.	Quantitative: Survey of 3,095 claimants using telephone interviews and accompanied web survey.	<u>Delivery:</u> Claimants who discussed their health with a Personal Adviser were more likely to take part in CMP than those who did not.	<u>Delivery:</u> Overall, a small number of claimants accessed CMPs. People with musculoskeletal conditions were less likely to take part in CMP.
NOTE: Abbreviations: CMP- Condition Management Programme, DWP, Department for Work and Pensions, JCP- Jobcentre Plus, PtW- Pathways to Work, NHS- National Health Service.					

Appendix 2: Sixteen papers from the database and web-based searches included in the review relating to the NHS-led Pathways to Work Condition Management Programme

Reference	Author	Date	Country	Study Design	Intervention	Comparison	Outcomes
1. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
2. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
3. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
4. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
5. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
6. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
7. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
8. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
9. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
10. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
11. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
12. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
13. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
14. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
15. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]
16. [Reference]	[Author]	[Date]	[Country]	[Design]	[Intervention]	[Comparison]	[Outcomes]

Report/paper	Author/year	CMP delivery	Method/data	Themes: benefits	Themes: drawbacks
				health and work agendas across agencies.	included: clearer evaluation measures for any new CMPs and for voluntary engagement in health-related support provision to be retained.
Identification of the factors associated with outcomes in a condition management programme.	Demou, Gibson and Macdonald (2012).	NHS-led.	Quantitative: Prospective cohort design using 2016 CMP data, participants' case notes and questionnaires pre- and post-CMP.	<u>Outcomes:</u> Improvements found in some participants' mental health on completion. Factors associated with improvements were: claimants' age, health condition and match between CMP practitioners' characteristics. <u>Delivery:</u> Telephone interventions were found to be successful for some claimants.	<u>Outcomes:</u> Low rate of programme completion.
Customers' perspectives on the impact of the PtW Condition Management Programme on their health, well-being and vocational activity.	Secker, Pittam and Ford (2012).*	NHS-led.	Qualitative: Focus groups involving 39 participants of CMPs.	<u>Outcomes:</u> Positive changes to claimants' perception of their health and ability to engage in work-related activities found.	Not identified.

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Assembling the evidence jigsaw: Insights from a systematic review of UK studies of individual-focused return to work initiatives for disabled and long-term ill people.	Clayton et al. (2011).	NHS-led.	A systematic review: 31 studies relating to UK employment programme interventions for people who have long-term illness. These included 10 studies which were PtW evaluations and 7 which concerned the PtW CMP delivery to 2006.	<u>Delivery:</u> The Personal Adviser's role was pivotal in supporting claimants' engagement in CMP. <u>Outcomes:</u> CMP content that addressed specific health needs was more effective than more generic interventions. Claimants' experiences of CMP were generally positive.	<u>Outcomes:</u> Limited up take of CMP overall within PtW programmes. <u>Delivery:</u> Personal Advisers had limited understanding of CMP and inappropriate referrals were made.
The clinical and occupational effectiveness of condition management for Incapacity Benefit recipients.	Kellett et al. (2011).	NHS-led.	Quantitative: Prospective cohort design. 2, 064 CMP participants pre- and post-questionnaires were analysed. These were psychological measures: the Clinical Outcomes in Routine Evaluation – Outcome Measure, Work and Social Adjustment Scale, Self-Efficacy Scale, and the Intrinsic Motivation Scale. Their employment status was also assessed at 3 stages.	<u>Outcomes:</u> Half of the CMP participants had a ' <i>reliable improvement in psychological well-being</i> ' (p164). A higher percentage of these improvements were found in people who had a mental health condition. 26% of CMP participants had made progress towards working or returned to work.	<u>Outcomes:</u> 49.5 % of CMP participants had no change or deterioration in their psychological well-being after CMP.
Promoting healthy routes back to work? Boundary Spanning and healthcare	Lindsay and Dutton (2011).*	NHS-led.	Qualitative study: Involving 52 semi-structured interviews with CMP staff.	<u>Delivery:</u> CMP practitioners played a crucial role in developing collaborative ways of working with JCP	<u>Delivery:</u> A minority of CMP staff experienced difficulties in adjusting to the different ways of

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<p>professionals and employability programmes in Great Britain.</p>				<p>staff. When working in a generic role, CMP practitioners also felt they could draw on their specialist professional skills. The complexity of CMP participants' lives required providing additional support and signposting to other services. This was found to stretch CMP practitioners' role boundaries.</p>	<p>working between JCP and CMP. Some CMP staff felt that some claimants had been coerced to attend CMP.</p>
<p>An evaluation of 3 NHS-led Condition Management Programmes in Wales.</p>	<p>Reagon and Vincent (2010).</p>	<p>NH- led.</p>	<p>Quantitative: 244 participants' outcome measurement scores. Qualitative: 12 interviews with purposeful sample of CMP staff: 3 managers; 9 (health care professionals); occupational therapists, physiotherapists and mental health nurses. Purposeful sample of 15 CMP participants who completed the programme.</p>	<p><u>Outcomes:</u> 'Statistically significant changes at the $p < .05$ level were observed in all outcome measure scores between the start and end of CMP intervention. These changes indicate that customers typically improve their physical and mental health (including levels of self efficacy) between the beginning and end of CMP' (p13). Improvements in self-</p>	<p><u>Delivery:</u> Some participants reported wanting more follow up. CMP could be too short in duration. Content could be difficult to understand for some claimants. Lay involvement wanted by some claimants.</p>

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Employability through health? Partnership-based governance and the delivery of PtW condition management services	Lindsay and Dutton (2010).*	NHS-led.	Qualitative: Interviews with 52 CMP practitioners working across the UK and senior NHS managers in Scotland who had strategic responsibility for the CMP.	management of condition, activity levels and reduction in pain. <u>Outcomes:</u> Positive increase in participants' mood and functional ability. Decrease in anxiety. Supported claimants to make progress towards working.	<u>Delivery:</u> CBT and group work was not always suitable for all participants. It was also found to be unable to support those with more complex health needs.
The role of interprofessional working in the PtW Condition Management Programmes.	Pittam, Secker and Ford (2010).*	NHS-led.	Qualitative study: Focus groups as part of a study undertaken for a realistic evaluation of the 7 pilot NHS CMPs. Commissioned by the Department of Health. 103 participants who delivered and managed CMPs, including: 5 Personal Advisers 9 Jobcentre Plus managers and 10 participants involved in external provider organisations.	<u>Delivery:</u> Claimants' receipt of a healthcare professional advice was perceived to add 'credibility' (p702). CMP staff had to learn how to adapt and work with staff within a different organisational culture.	<u>Delivery:</u> Limited support available for claimants with more complex needs.
Patient perspectives of Condition Management Programmes as a route to better health, well-being and employability. Finding a clearer path.	Joyce et al. (2010).	NHS-led.	Qualitative: 4 focus groups and 9 semi-structured interviews involving a total of 25 participants.	<u>Outcomes:</u> Positive increases in claimants' health behaviours. More optimistic outlook about health and well-being and returning to work.	<u>Delivery:</u> Lack of follow up after some CMPs raised questions about the effectiveness and ethics of providing a short-term programme.
	Macmillan	NHS-	Qualitative evaluation: 16 Semi-	<u>Delivery:</u> Being able to talk	<u>Delivery:</u> Content not

Report/paper	Author/year	CMP delivery	Method/data	Themes: benefits	Themes: drawbacks
Evaluation of the Pathways to work Programme for individuals living with cancer.	Cancer Support (2010).	led.	structured telephone interviews with cancer survivors, 31 front-line staff and managers who worked in PtW programmes.	to a CMP practitioner was helpful. <u>Outcomes:</u> Increased confidence and self-esteem. Meeting other claimants with similar needs was a positive experience.	always suitable to meet participants' cancer related needs. Not sufficiently work-focused. Limited integration and sharing of information between services.
Realistic Evaluation of the Impact and Outcomes of the Condition Management Pilots. Evaluation for Department of Health.	Ford and Plowright (2008).*	NHS-led.	Quantitative and qualitative: Analysis of CMP participants' questionnaires (outcome measures), workshops, interviews and focus groups with staff involved in the 7 NHS pilot sites.	<u>Delivery:</u> 'Strong relationships with Jobcentre Plus were associated with increased work outcomes' (p85) for claimants. <u>Outcomes:</u> CMP participation was associated with a 'significant reduction in anxiety and depression' (p11).	<u>Delivery:</u> Stakeholders felt that the CMP should be longer with follow-up.
Condition Management: A qualitative investigation of the Customer experience.	Kellett et al. (2008).	NHS-led.	Qualitative: 10 focus groups were randomly selected from 50. Mean size of focus group was 3.27.	<u>Outcomes:</u> Positive changes to participants' attitudes towards work. Some participants were applying for work or had returned to work. Others were in education.	<u>Delivery:</u> Group work could cause initial anxieties. Length of CMP was too short. Some participants wanted more of a work focus.
Finding a pathway back into work.	Christie and Marshall (2008).	NHS-led.	Qualitative: Longitudinal series of 3 semi-structured interviews with 23 CMP participants.	<u>Outcomes:</u> increase in self-management of a condition. Some	<u>Delivery:</u> Better marketing of the CMP was felt to be needed.

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				participants were in paid work, and others were volunteering or seeking work after completion of CMP.	
<p>NOTE: * Indicates data is likely to relate to another article by the same author within the table. Abbreviations: CBT- Cognitive behavioural Therapy, CMP- Condition Management Programme, DWP- Department for Work and Pensions, JCP- Jobcentre Plus, PtW- Pathways to Work, NHS- National Health Service, Prime - Primary Contractor.</p>					

Author and date	Study aims	Methods	Participants
		<p>Follow up interviews with Personal Advisers and claimants. Data collection took place between March and June 2006.</p>	
<p>Patel, Greasley and Watson (2007).</p>	<p>To explore the perceived barriers to returning to work of unemployed people who have chronic musculoskeletal pain.</p>	<p>Qualitative study. In-depth interviews.</p>	<p>38 patients (15 men/23 women) aged between 29 and 62 years.</p>
<p>Fletcher (2008).</p>	<p>To explore any challenges that Jobcentre Plus experiences when support is provided to claimants in areas of worklessness.</p>	<p>Qualitative study. Case study work in one area. This area was part of a larger evaluation of the Working Neighbourhoods pilot that was commissioned by the DWP.</p>	<p>This study took place over a two year period. It involved interviews with local stakeholders which included Personal Advisers and JCP managers. The study also involved claimants who received IB.</p>
<p>Townsend (2008).</p>	<p>To explore the knowledge and experience of professionals who support people with multiple sclerosis into work. To identify current practice and training needs of professionals supporting people with multiple sclerosis in work.</p>	<p>Survey: postal questionnaire.</p>	<p>Participants included: 32 Occupational Therapists who were involved with people who had multiple sclerosis, 30 multiple sclerosis specialists and 8 Disability Employment Advisers.</p>
<p>Riach and Loretto (2009).</p>	<p>To gain an understanding of how older claimants manage their self-identity in relation to work.</p>	<p>Qualitative. Focus groups as part of the project commissioned by the Scottish Enterprise.</p>	<p>8 focus groups with 66 participants. 19 of the participants were in receipt of IB and 35 received JSA. 54 men and 12 women. The age range was between 50 to 65 years.</p>
<p>McNeil</p>	<p>To examine the role of the Personal Adviser in the welfare-</p>	<p>Mixed methods study.</p>	<p>Involved service users, Personal Advisers and</p>

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(2009).	to-work system.	In-depth interviews, focus groups and online survey.	employment provider organisations' perspectives. 3 focus groups with 24 service users from one locality in South London. 6 in-depth interviews with Personal Advisers. Online survey involving Personal Advisers. Online survey with employment support provider organisations. Site visits to welfare-to-work provider organisations and interviews with stakeholders.
Nice, Irvine and Sainsbury (2009).	To explore the Jobcentre Plus Personal Adviser referral and liaison practices for people who receive incapacity related benefits.	Qualitative study. Commissioned by the DWP. In-depth interviews and group interviews. Study took place in 2007 and 2008.	Incapacity Benefit Personal Advisers (IBPA) and Disability Employment Advisers (DEA) and frontline staff in other organisations that provided back to work services for claimants who received IB. 20 IBPAs from 18 different JCPs. 20 interviews with frontline staff in 5 provider organisations 8 interviews with DEAs 4 group interviews with 20 IBPAs. Covered 4 JCP Districts.
Hudson et al. (2009).	To explore how employment services can support people with mental health conditions more effectively.	Qualitative study. Commissioned by the DWP. Data collection -Jan 2008 and February 2009. Four phases including: In-depth interviews with key stakeholders and	28 stakeholders including DEAs, IBPAs, CMP managers and practitioners who were involved with claimants who had mental health conditions. 44 claimants.

Author and date	Study aims	Methods	Participants
		claimants with mental health conditions.	
Hudson et al. (2010).	To understand how targets might influence Personal Advisers in provider organisation led programmes.	Qualitative study. Commissioned by the DWP. In-depth interviews, workshops and fieldwork.	Frontline staff including Personal Advisers in provider organisation led PtW contracts.
Green and Shuttleworth (2010).	To identify if there are any differences between IB claimants perceived and actual profiles. To understand how policy can tackle local variations for claimants and whether it fits a local perspective.	Mixed methods study. Surveys and focus groups. Survey took place between October 2006 and March 2007. Focus groups took place in 2008.	Personal Advisers within Northern Ireland including the six areas. Survey of 803 IB claimants with 55% response rate.
Drew et al. (2010).	To identify Personal Advisers' styles and techniques that enabled claimants to move closer to a return to work. To identify effective practice for Work Focused Interviews.	Qualitative study. Commissioned by the DWP. Observation of 188 video recordings of Work Focused Interviews. Study took place between May 2007-May 2009.	47 Personal Advisers and claimants engaged with 8 JCP and 2 Employment Zones. Three claimant cohorts: i) Lone parents in receipt of income support. ii) People in receipt of JSA. iii) People in receipt of benefits due to ill health or disability This study involved 20 Work Focused Interviews that were conducted by 7 Personal Advisers. Claimants who were involved with the Personal Advisers agreed to participate.

Author and date	Study aims	Methods	Participants
Barnes et al. (2010).	To explore the experiences of ESA claimants and the staff who they are involved with.	Qualitative study. Commissioned by the DWP. In-depth interviews. Study carried out in May -June 2009.	38 staff within JCP and provider led organisations including Personal Advisers and managers. 39 claimants.
Nice and Davidson (2010).	To explore experiences of people supplying CMP within provider organisation led PtW and those who accessed the services.	Qualitative study. Commissioned by the DWP. 3 main phases including: interviews with PtW and CMP staff and claimants who had engagement with CMP. Study carried out in 2009.	15 Personal Advisers who referred to CMP. 14 CMP practitioners. 36 CMP clients. 10 PtW managers who monitor CMP and managers within contracted CMP. Covered four districts.
Macmillan Cancer Support (2010).	Evaluation of PtW for people living with cancer.	Qualitative study. Workshops involving JCP and CMP employees. Telephone interviews. Study took place in 2009/10.	16 semi-structured interviews with cancer survivors. 31 frontline staff and managers who worked in PtW.
Grant (2010).	To investigate the experiences of the staff and clients of JCP and the CMP in two areas of Wales	Qualitative. Early findings from a PhD study. Semi-structured interviews. Data collected June 2008-March 2009.	41 participants from four groups. 8 JCP DEAs who also worked as IBPAs. CMP clinical staff and managers. IB claimants accessed via CMP. 11 'unengaged' IB claimants.

Author and date	Study aims	Methods	Participants
Pittam, Secker and Ford (2010).	To explore the perceptions of participants involved in the operational aspects of CMP and impact on participants and local health and social care economy.	Qualitative study. Focus groups.	103 participants who deliver and manage CMP including: 5 IBPAs and 9 JCP managers and 10 participants involved with external provider organisations.
<p>NOTE: Abbreviations:-CMP- Condition Management Programme, DEA- Disability Employment Adviser, ESA-Employment Support Allowance, IB- Incapacity Benefit, IBPA- Incapacity Benefits Personal Adviser, JCP- Jobcentre Plus, JSA-Job Seeker's Allowance, PtW- Pathways to Work , NNDP- New Deal for Disabled People, New Deal for 25+- ND25+ , WFI- Work focused interview.</p>			