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**Department for Work and Pensions**

**Research Report No 494**

# **The Pathways Advisory Service: Placing employment advisers in GP surgeries**

**Roy Sainsbury, Katharine Nice, Camilla Nevill, Martin Wood, Josie Dixon and Martin Mitchell**

A report of research carried out by Social Policy Research Unit and National Centre for Social Research on behalf of the Department for Work and Pensions

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# Summary

## Introduction

This report presents findings from evaluation research to explore the impact and effectiveness of a pilot project commenced in 2006 to locate employment advisers from Jobcentre Plus in GPs' surgeries. The study was carried out by the Social Policy Research Unit (SPRU) at the University of York and the National Centre for Social Research (NatCen) in 2006 and 2007.

Apart from the innovative measure of physically locating advisers in surgeries, a distinctive feature of the pilot has been the adoption of a 'gateway' model of delivery, where advisers act as a link, or 'gateway', between patients at a surgery and the range of services and support available through Jobcentre Plus and other organisations.

A particular aim of the pilot has been to provide early help and support to people on Statutory Sick Pay (SSP) and to long-term Incapacity Benefit (IB) recipients who are not required to attend Work Focused Interviews (WFIs) as a condition of receiving benefit under the Pathways to Work arrangements.

The research project combined quantitative and qualitative research techniques. A survey of people who had used the pilot service was conducted and in-depth qualitative follow-up interviews were carried out with a sub-sample of the survey sample. In addition, qualitative interviews were held with the key people involved in the pilot (including advisers, GPs and other surgery staff).

## Engaging potential Pathways Advisory Service users

Most patients came to learn about the Pathways Advisory Service through discussions with their GP. Alternatively, some people were told by another surgery practitioner or staff member and referral through these personnel appeared to be growing. A range of methods advertising the service to patients who did not often visit their GP were trialled with limited success and included notices attached to sickness certificates and prescriptions, pieces in surgery newsletters and letters to people making a repeat claim for IB.

GPs' understanding of the purpose of the Pathways Advisory Service influenced which patients they discussed it with. All were aware that the aim was to get IB recipients back to work. Within this broad aim there were many GPs who thought the Pathways Support Adviser (PSA) could provide advice on the effect of working or other activity on social security benefits, could provide a benefit check and had access to other forms of financial assistance. These aspects of the PSA role were welcomed by GPs who perceived their own lack of knowledge about benefits and employment programmes as a hindrance to helping their patients. When talking to patients about the service, most GPs felt they were capable of being persuasive, but were reluctant to 'push' people further than they wanted to go because of the potential for damage to the doctor-patient relationship.

Some GPs noted that, over time, they had become less selective in who they referred to the PSA. They had learned from previous referrals that their perception of an individual's distance from the labour market was not necessarily an indicator of whether they could be helped by the PSA and, ultimately, the likelihood of their finding work. Their confidence and trust in the PSA had also grown over time.

For GPs, it was important that the PSAs were based on the surgery premises as this enabled easier referral procedures, which could sometimes be immediate and could avoid the need for formal, written referrals. PSAs' presence in the surgery also aided the fostering of good relationships with practice staff.

Given the aim to help people receiving IB or SSP into work, a lower than expected number of people who spoke with a PSA were on these benefits. The survey data shows that a range of benefits were being received by people meeting the PSA and that some people were not in receipt of any benefits. There is, thus, an argument that the desire for employment and other advice is not restricted to those on health-related benefits, and that the PSA could be of help to many interested people not currently in contact with Jobcentre Plus. The third of patients who saw a PSA and said they were off work temporarily suggests a particular demand for job retention advice.

Survey participants cited a wide range of reasons for deciding to meet with a PSA, with non-work-related reasons as common as those concerned with work. There was evidence that some people spoke to the PSA because they felt under pressure to do so and some others felt they had not fully understood the purpose of the meeting beforehand.

In the majority of cases, GPs took responsibility for making the patient's appointment with the PSA. On the whole, seeing the PSA the same day as the GP consultation was perceived as convenient, but this practice was criticised by people who felt they did not have sufficient time to consider their participation. On the other hand, appointments at a later date and time allowed for thought and preparation in advance.

## Content and outcome of meetings with Pathways Support Advisers

In general, most conversations with PSAs covered the client's health, family background, employment history, education and qualifications. PSAs had the impression that most people wanted to talk about either work, benefits or health but usually a combination of these and that the meeting had been in some way constructive. The survey data show how PSAs covered a large volume and broad range of topics in the meeting, not all of which were about getting back to work.

Mirroring the variety and scope of the topics discussed, PSAs described a wide range of support options that they had suggested to patients. Most of their referrals were to Jobcentre Plus advisers or the Condition Management Programme (CMP) but they had extensive knowledge of other externally-provided services encompassing advice organisations, community organisations, education providers and Government departments. It was rare for PSAs to make no suggestion at all.

PSAs were aware that they had seen some people who were currently in contact with the Pathways to Work programme or who had 'been through' Pathways at some point previously. Nevertheless, they felt they had a role in helping such people by providing reassurance about the applicability of the Pathways scheme or by re-engaging them with the idea of work and perhaps renewing links with Jobcentre Plus staff.

Conversations about a patient's benefit status often led to advice to apply for a different or additional benefit. Sometimes, PSAs recommended that patients claim IB because they would then become eligible for the support offered through Pathways to Work which was felt would contribute more constructively to a gradual return to work

There was evidence that people who did not choose to meet the PSA for a work-related reason could be engaged in discussions about work. Further to this the discussion could result in a recommendation from the PSA to meet with an adviser at Jobcentre Plus or to take part in the CMP. Among those who went to the PSA wanting to discuss work, nearly half had progressed to talking about applying for jobs during the meeting.

The patient survey showed high levels of satisfaction regarding the meeting with the PSA, with 91 per cent rating it as either 'very' or 'quite' helpful. People who found the meeting helpful explained that the PSA had encouraged and motivated them to think about work, had clarified employment options, had provided advice about benefits and permitted work and had informed them about help and support that might be available. People who were critical of the meeting with the PSA felt that the PSA did not offer enough support, that the suggestions made were unhelpful and that information was incomplete, inaccurate or confusing.

## Further activity after the Pathways Support Adviser meeting

The study explored what happened after the meeting with the PSA using the survey of patients three months later, and through qualitative follow-up interviews with a sub-section of the survey population at a later stage.

Three months after the meeting, half of the suggestions made by PSAs had been acted upon by patients. Two-thirds of people who had been advised to see a Jobcentre Plus adviser had done so and a large proportion of those who had not planned to do so in the future. There was further evidence that the Pathways Advisory Service activated people who were not originally thinking about work, as 77 per cent of people who had a non-work-related reason for seeing the PSA followed up the suggestion to speak to an adviser at Jobcentre Plus. Within three months of speaking with a PSA, some people's work status had changed and a total of seven more people were in work than were at the time of the meeting.

The qualitative follow-up interviews, at a later point after the meeting, showed that a range of services and support options had been engaged with by patients, including Jobcentre Plus advisers, the CMP, work psychologists, Job Brokers and Work Preparation schemes, employer-provided occupational health services and a range of health management focused courses.

These referrals were usually considered to have been appropriate and helpful. In general, people gave favourable impressions of staff and services where they felt they had been listened to, that their needs had been understood, that appropriate support had been offered and their needs had been met. Disappointments and problems were experienced when people felt that they had not been well understood such that the support offered was inappropriate, when they could not receive the help they thought would be available and when they found that the help offered (for example, training or voluntary work) did not meet their needs.

Of those who were in work at the time of the research interview, all said that the contact they had with the PSA, Jobcentre Plus staff or other services had been useful and contributed positively to their progress. There were people in the study group who had not returned to work but had moved closer to employment by, for example, taking up voluntary work, who also described positive benefits from meeting with advisers and undertaking work-focused activities. People who did not appear to have moved closer to work were generally positive about the help from the PSA and other services but perceived barriers to making progress including health, caring responsibilities and job market constraints.

## Assessing the pilot

The effectiveness of the Pathways Advisory Service pilot could not be measured quantifiably but a qualitative assessment was possible based on various interested parties' perceptions of the difference made by the pilot.

Overall, GPs were enthusiastic and positive about the pilot and this is perhaps unsurprising given that they had volunteered to take part. Nonetheless, their assessments are valuable for highlighting the elements of the service that worked particularly well. They valued the access to employment and benefit advice that they could not provide themselves and felt that they could engage in a discussion about work with patients on a much more constructive basis than previously. The physical presence of the PSA in their surgeries for some part of every week was also important in making referral an easy (and sometimes immediate) process and in getting to know and trust the adviser. They also noted examples of positive impacts on patients, such as taking up employment, improvements in health and increased income.

PSAs discussed the importance of their role in linking health with employment interventions in a much more visible and collaborative way than previously. Being placed in GP surgeries was considered vital to the effectiveness of the service, as it created the opportunity to speak to people who might not otherwise have contact with Jobcentre Plus. Referral from a GP or other health practitioner, and thus, their endorsement of the service, was also important in encouraging people to engage in appropriate work-related activities. The PSAs themselves recognised that the role of the PSA demanded a certain armoury of skills in order to work with GPs, surgery staff, their colleagues at Jobcentre Plus and to act as motivators with patients.

Survey participants and those who were interviewed at a later stage were also asked for their views on the difference made by the pilot. There are findings to suggest that many patients who attended a meeting with an adviser at Jobcentre Plus only did so because they had first met with a PSA. Views amongst people who were in work at the time of the follow-up interview were that the PSA had been influential in their route back to work. Other ways in which the PSA was said to have made a difference were by providing more help than had been received previously in past contacts with Jobcentre Plus and by presenting an opportunity to look at options in more depth.

The survey provides strong evidence that the one-meeting gateway model was adhered to for the large majority of people. However, there were exceptional occasions when PSAs said they would have contact with a client more than once. This might happen when they felt that the initial meeting had come at the wrong time for the patient and had suggested that they return when more ready to think about work. Further contacts might also occur if the PSA felt the patient needed encouragement or 'moral support' or where they perceived the need to intervene in a case where the patient was making little progress.

## Conclusions and policy implications

The research findings suggest that the four main pilot aims have been largely met and that the 'gateway' model of delivery is a viable mechanism for connecting people with a range of employment and other support:

- **Provision of early help and support to SSP recipients** – The Pathways Advisory Service has provided advice and guidance to people in work as well as those out of the labour market. Although few people on SSP have made use of the pilot, the data on their experiences demonstrates the potential of the gateway model to help people still in work.
- **Encouraging new contact with Jobcentre Plus services** – There is strong evidence that people who were unlikely to make contact with Jobcentre Plus offices themselves attended meetings with a range of advisers and CMP practitioners after meeting a PSA, with many going on to undertake some kind of work-related activity. Endorsement from GPs was important in moving people towards work and locating PSAs in GP surgeries made referral easy, quick and comfortable for patients.
- **Deepening the relationship between health professionals and Jobcentre Plus** – The pilot arrangements fostered a mutually useful connection between GPs and Jobcentre Plus.

In particular there were gains for GPs in increased knowledge of the help available through Jobcentre Plus. Jobcentre Plus staff also benefited because they met people who were, in some way, engaged with the idea of returning to work because of their discussions at the surgery.

- **Helping GPs to help their patients move towards work** – GPs found that the increased awareness and appreciation of the employment and financial help available enabled them to have much more informed and constructive conversations with their patients about moving towards work.

Additional conclusions from the study were that:

- people had wider information and support needs beyond employment and the PSA was mostly able to offer assistance in meeting these needs;
- GPs and PSAs addressed barriers to work and barriers to attending Jobcentre Plus by encouraging constructive and positive thinking and allaying concerns;
- the personal qualities of PSAs appear to be crucial to the acceptability and usefulness of the service within surgeries.

The research highlighted policy implications in the context of the commitment to expand the pilot and the introduction of the new Employment and Support Allowance in October 2008. Implications are that:

- principal components of the pilot design – experienced staff as PSAs, location in surgeries, the ‘gateway’ model – are effective and could be promoted to attract new GP surgeries to use the Pathways Advisory Service;
- it is unlikely that targeting the service at only people receiving SSP or IB would be welcomed by many GPs;
- advisers who take on the PSA role need to have a range of advanced knowledge and interpersonal skills;

- possible policy responses to draw in more patients to the Pathways Advisory Service are to increase knowledge and understanding of the service among GPs and other practice staff; and to encourage patient self-referral by using and repeating multiple methods of publicising the service;
- GPs have developed 'effective practice' in talking to patients about work and this could be usefully disseminated amongst other GPs;
- clarification is needed regarding the effects of data protection legislation on PSAs' and GPs' capacity to share patient information;
- any management targets would seem unsuitable because of the unpredictable flow of referrals from GPs, and because PSAs found it constructive to be able to work flexibly with individual clients.

People who will fall outside the remit of Employment and Support Allowance could still benefit from a Pathways Advisory Service.





# 1 Introduction

This report presents findings from evaluation research to explore the impact and effectiveness of a pilot project commenced in 2006 to locate employment advisers from Jobcentre Plus in GPs' surgeries. The study was commissioned by the Department for Work and Pensions (DWP) and carried out by SPRU at the University of York and NatCen in 2006 and 2007.

Apart from the innovative measure of physically locating advisers in surgeries, a distinctive feature of the pilot has been the adoption of a 'gateway' model of delivery. In this model advisers act as a link, or 'gateway', between patients at a surgery and the range of services and support that is available through Jobcentre Plus itself and the wide network of external organisations that provide employment-related services.

A particular aim of the pilot has been to provide early help and support to people on SSP and to long-term IB recipients who are not required to attend WFIs as a condition of receiving benefit under the Pathways to Work arrangements.

The research project combined quantitative and qualitative research techniques. A survey of people who had used the pilot service was conducted and in-depth qualitative follow-up interviews were carried out with a sub-sample of the survey respondents. Qualitative interviews were also held with the key people involved in the pilot, including advisers, GPs and other surgery staff.

In this introductory chapter we begin by setting out the policy background to the pilot (Section 1.1) and details of the 'gateway' model adopted (Section 1.2). The aims and objectives of the study and a summary of the principal research questions that were explored are in Section 1.3. In the section on research design (Section 1.4) we explain the approach taken in this study to assessing the outcomes and the effectiveness of a 'gateway' service compared with other welfare to work provision. The methods used in the study are explained in more detail in Section 1.5 alongside data describing the main characteristics of the survey sample.

This report has synthesised data and findings from all the elements of the research design in order to present a thematic analysis covering how patients come into contact with an adviser (Chapter 2), the content and outcomes of meetings

between advisers and patients (Chapter 3), subsequent activity and outcomes for people who have met an adviser (Chapter 4) and an assessment of the overall impact of the pilot 'gateway' service (Chapter 5). In the final chapter we set out some of the implications of the study that can inform future policy thinking.<sup>1</sup>

## 1.1 Policy background

There has been much policy activity since 1997 aimed at helping people who are on long-term sickness and disability benefits move towards and into work (including New Deal for Disabled People (NDDP) and the ongoing Pathways to Work programme). One consistent feature of these welfare to work policies is that where participation by benefit claimants has been voluntary, the take up of the opportunities available has been lower than hoped. For example, despite initial findings about the positive impact of the Pathways to Work programme, it is also apparent that many long-term recipients of IB do not engage with it (Bewley *et al.*, 2007).

Another unresolved aim of welfare to work policy has been to keep people who are on sickness leave in contact with the labour market so that a move to IB becomes unnecessary.<sup>2</sup>

As a response to both of these policy objectives, an announcement was made in the 2004 Pre-Budget Report and later confirmed in the Green Paper *A New Deal for Welfare: Empowering people to work* (DWP, 2006), to pilot the use of employment advisers, known as **PSAs**, in GPs' surgeries. The pilot commenced in late January 2006 with the original intention of running for two years.

The idea of placing advisers in GP surgeries is not entirely new, having been taken up in recent years by a number of organisations including Jobcentre Plus (in some local initiatives), Citizens Advice offices and commercial organisations in the employment agency/job broker sector. These initiatives have been largely small-scale in nature and have varied in a number of ways, including the range of services offered, the type of personnel acting as advisers and the frequency of attendance by advisers at surgeries. However, the DWP pilot differs from these initiatives by limiting the adviser role to a 'gateway' service, which the next section explains.

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<sup>1</sup> At the time of writing (December 2007) an announcement was made by the DWP that the pilot's coverage is to be extended in 2008 (DWP Press Release, 'New support for employers and GPs to tackle stress-related sicknotes', 27 November 2007).

<sup>2</sup> One policy innovation, the Job Retention and Rehabilitation Pilot, that ran from 2003 to 2005, did not prove effective over other forms of job retention activity (Purdon *et al.*, 2006).

In summary the overall aims of the pilot, as set out by DWP, were to:

- encourage people who have little contact with Jobcentre Plus, including existing IB recipients, to access appropriate return to work services;
- provide early help and support through Pathways to Work to people on SSP to prevent the development of a health condition or disability leading to the loss of a job;
- deepen the relationship between health professionals and Jobcentre Plus;
- increase GPs' ability to help their patients progress towards work by providing access to interventions not available through standard National Health Service (NHS) services.

## 1.2 The 'gateway' model of delivery

In contrast to other similar initiatives, the DWP pilot has been predicated on a 'gateway' model of service provision. Under this model, people of working age visiting a surgery or medical centre are offered employment and other advice by a PSA. Contact with a PSA can be through self-referral or referral from a GP, other practice worker or externally via a health worker in, for example, a community mental health team. In the pilot the Pathways Advisory Service has been open to anyone attending a GP surgery, regardless of their employment or benefit status.

The meeting with a PSA was intended to be a one-off event in which a patient is provided with information, advice and guidance only. Under the 'gateway model' advisers do not generate a 'caseload' of people with whom they would keep in contact or offer ongoing services. The intention is to connect people with existing services rather than duplicate them. Therefore, where appropriate, advisers make referrals to other service provision, principally to Pathways to Work advisers, the CMP, other Jobcentre Plus services and external organisations such as Citizens Advice or local authority services. An innovative feature of the pilot has been to extend the eligibility for some services to a wider group of people. In particular, the CMP, previously restricted to Pathways to Work clients, was made available to claimants of SSP.

The Jobcentre Plus districts where the pilot has been introduced<sup>3</sup> were allowed a degree of flexibility in how the 'gateway' model was implemented. In two districts CMP practitioners were more heavily involved in liaising with surgeries and meeting patients. PSAs were recruited from Jobcentre Plus staff; some had previous experience as IB Personal Advisers and others had different backgrounds.

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<sup>3</sup> The areas involved in the pilot have been: Argyll and Paisley; Bridgend, Rhondda Cynon Taf; East Lancashire; Gateshead and South Tyneside; Somerset.

### 1.3 Aims and objectives of the study

The overall aim of the research study was to assess the extent to which the Pathways Advisory Service met the policy objectives set out in Section 1.1.

To achieve this we defined a number of research questions that could be explored. These are summarised below.

#### **For GPs:**

- What is their understanding of the role of the PSA and the help they can provide?
- How do GPs choose which patients to tell about the Pathways Advisory Service?
- How do they explain the PSA to patients?
- How do they work with PSAs?
- What have been their experiences of the pilot?
- What beneficial or other effects has taking part in the pilot had?
- What are their reflections on locating advisers within their surgeries?

#### **For PSAs:**

- What type of patients do GPs refer to them?
- What is the range of help they have provided?
- Which patients cannot be helped?
- What are their experiences of operating a 'gateway' model of delivery?
- Do they think they are providing new, additional and useful forms of help to people?

#### **For people who have met with a PSA:**

- What are people's experiences of being referred by their GP to a PSA?
- What are their experiences of the form and content of the meeting with a PSA?
- What contribution have PSAs made to their lives, especially in moving towards work?
- What further action resulted from meeting the PSA?
- What are their reflections on what they would have done if they had not met a PSA?

These research questions could only be addressed by a research design that combined quantitative and qualitative data collection and analysis techniques. These are described in the next section.

It should be noted that the nature and scale of the pilot precluded any attempt at a formal 'impact assessment'. Neither a random controlled design nor any alternative quasi-experimental methods, were considered suitable or feasible. Section 1.4 sets out how we addressed the need to generate understanding of whether the pilot met its objective of changing people's behaviour by engaging them in some form of work-related activity.

## 1.4 Research design

The research design was not only determined by the research questions above, but also by two design challenges. The first was how to measure the impact and effectiveness of a 'gateway' service and the second was how to measure the **counterfactual**, i.e. what people would have done had the Pathways Advisory Service not been in place.

In this section we discuss these two design issues and how they were resolved, before describing the overall research design which, it should be noted, was revised during the course of the pilot.

### 1.4.1 **Assessing the effectiveness of, and the difference made by, the Pathways Advisory Service**

Although the aim of all welfare to work policies is to increase the numbers of people entering work and leaving benefits, the Pathways Advisory Service was not intended as a job searching or job brokering service. The PSA's main aim has been to **connect** people to appropriate help that might move them towards work. This might be, for example, immediate job search or job brokering help but might be some form of intermediate step, such as the CMP, voluntary work or debt advice. Thus, whether or not someone eventually enters work is likely to be dependent on people other than the PSA. It is important, therefore, to recognise that any indicator of effectiveness must realistically reflect what advisers can be expected to achieve and is within their power to influence. The effectiveness of advisers cannot be measured directly in job outcomes. Also, it was always apparent from the size and design of the pilot that any form of experimental research design to measure the counterfactual (such as a randomised control trial) was not possible.

We have, therefore, adopted an approach which draws on the views of the main actors (particularly patients') own subjective assessments of how useful the PSA meeting was in moving them forwards, whether referrals were actually acted upon, and the impact on any subsequent activity. We have looked for evidence, therefore, of some sort of 'progress' for the patient which might be towards paid work (or some interim activity on the trajectory towards work, such as training or debt counselling) or towards some other form of socially inclusive activity. We have also relied on the evidence of the GPs to assess whether having a PSA in their surgery has been a positive experience and the extent to which the service has added to how they can help their patients.

### **1.4.2 Original and final research designs**

As mentioned already the research design changed during the course of the study. The original intention was to carry out a survey of 500 users of the Pathways Advisory Service around two to three months after their meeting and to follow up the sample some six months later. The first interview was intended to gather data on the experience and outcomes of meeting the PSA and on any action or activity that followed soon after. The second interview was intended to collect data on activity over the longer-term that would allow us to look at longer-term outcomes.

However, fewer patients than expected were referred to, and seen by, a PSA and it became apparent soon after the start of the study that (a) a target of 500 could not be achieved within a reasonable timeframe and (b) following up survey respondents six months after their first interview would extend fieldwork too far into 2008 to be useful for informing policy. The decision was taken to curtail survey fieldwork in September 2007 and to replace the follow-up survey with a qualitative follow-up interview of 45 people who had been surveyed in January and February of 2007.

The overall design that was achieved was as follows:

- a survey of people who had had a meeting with a PSA;
- qualitative follow-up interviews with a sub-sample of survey respondents, six months after the survey interview;
- qualitative interviews with PSAs, GPs and other practice staff.

We set out further details of these elements of the study in the next section.

## **1.5 Research methods**

### **1.5.1 Survey of people using the Pathways Advisory Service**

A survey of 212 people who had had a meeting with a PSA was carried out in 2007. The survey consisted of 20-minute telephone interviews conducted on a rolling basis within three months of meeting with the PSA. The aim of the survey was to assess how the pilot was working in practice and in particular to provide data on who was participating in the pilot, any short-term actions or referrals that resulted from the meeting and an assessment of the service provided.

As mentioned above, because the expected number of people using the services of a PSA was much lower than expected, interviewing continued as late into the research project as possible until fieldwork was stopped in September 2007.

The main characteristics of the achieved sample are presented in Table 1.1.

**Table 1.1 Main characteristics of the survey sample**

Main characteristics	N	%
<b>Sex</b>		
Male	120	57
Female	92	43
<b>Age band</b>		
16 to 34	75	36
35 to 44	57	28
45 to 54	47	23
55 and over	27	13
<b>Main health condition</b>		
Musculo-skeletal	54	26
Chronic/systemic conditions	40	19
Mental health conditions	82	40
Sensory impairment	3	1
Other	17	8

Base: All respondents.

In general this was a diverse population covering the main socio-demographics. The proportions of men and women in the sample were very similar, with slightly more men (57 per cent) than women (43 per cent). There was also a wide spread of ages with just under two-thirds being under the age of 45 (64 per cent). These proportions are very similar to that found in the general Pathways to Work population (Bailey *et al.*, 2007). In two-fifths of cases, the main condition of the respondent was a mental health condition or disability. The second most common conditions were musculo-skeletal, with just over a quarter (26 per cent) of respondents reporting this to be their main condition. A greater proportion of people in this population reported having mental health conditions than in the Pathways to Work population and fewer report having musculo-skeletal conditions. Six per cent of respondents reported having no health condition.

Three-quarters of the population described themselves as white (73 per cent), and 23 per cent described themselves as Asian. In the Pathways to Work population 96 per cent describe themselves as white and only two per cent describe themselves as Asian. This anomaly is explained by one of the pilot districts being sited in an area with a high Asian population.

Forty-two per cent of the population were married or living as married and in over half of these cases (56 per cent) their partner was not in a paid job. Just under half (46 per cent) had a child under the age of 16 living in their household.

### **1.5.2 Qualitative follow-up study of survey respondents**

Survey interviews were generally carried out around three months after the meeting with the PSA. As noted above, it was not possible to gather data from the survey



about the longer-term effects of the meeting. Hence, the important research question of whether PSAs were meeting the policy aim of starting people on the path towards work that they might not otherwise have taken was addressed in a qualitative follow-up study conducted approximately six months after the survey interviews.

The study involved 20-minute long qualitative telephone interviews with a total of 45 participants from the survey who gave their consent to be contacted for a follow-up interview and who subsequently agreed to take part when contacted. The interviews were used to explore, in more depth, experiences of referral from GPs and meetings with PSAs as well as what happened to people in the months after seeing the PSA.

Key issues addressed in the interviews included:

- current position in relation to work;
- extent and usefulness of contact with a PSA;
- referrals to other provision and the usefulness of these referrals in making progress towards work;
- health and other factors that may have impacted on the return to work;
- routes into employment, including the extent of involvement of the PSA and other services;
- views about the sustainability of work and the future more generally.

Attempts were made to ensure inclusion of a range of experiences in relation to gender, age, employment status, benefits received and health conditions. The achieved sample largely reflected the survey sample, except that the qualitative sample was skewed towards the older age groups.

### **1.5.3 Qualitative interviews with key actors**

Qualitative data was generated using a mix of individual and group interviews with the key actors in GP surgeries, including:

- eight individual GP interviews in late 2006/early 2007;
- ten individual GP interviews in late 2007 (including four GPs interviewed in the first wave);
- six individual interviews with PSAs, CMP practitioners and Pathways to Work managers;
- two group interviews with PSAs and Pathways to Work managers;
- seven interviews with other practice staff (including five Practice Managers, one counsellor and one drugs worker).

Interviews were recorded with permission and data extracted either from transcripts or direct from recordings.

## 1.6 Structure of the report

Chapter 2 looks at how patients in GP surgeries come into contact with PSAs and their motivations for attending the meeting. The referral practices of GPs are also examined and a comparison made between the types of people using the Pathways Advisory Service and the target population for the pilot.

In Chapter 3 data from the survey and PSA interviews are used to explore, in detail, the content and outcome of meetings between surgery patients and PSAs. An analysis of users' views about the usefulness of the meetings and how they contributed to thinking about work is also presented.

Chapter 4 looks at what happened to people after their meeting with a PSA, firstly in the short-term (i.e. in the three months or so between meeting a PSA and the survey interview) and how their employment and benefit status had changed in this time. From the follow-up interview data we then examine people's experiences of longer-term changes in their circumstances.

In Chapter 5 we draw on the reflections of patients, GPs and PSAs to assess the effectiveness of the pilot from their different perspectives. We attempt to draw some conclusions about the difference made to people's lives because of their engagement with a PSA.

Chapter 6 concludes the study by setting out some of the policy implications of the findings.

## 1.7 Using this report

Due to the small size of the survey the quantitative findings need to be viewed with some caution. While the results are indicative of the how the pilot is working, we can be less confident in their accuracy than if we were reporting results based on a larger sample size. The response rate for the telephone survey was 56 per cent.

We have adopted a number of standard reporting conventions for the survey findings. Weights were applied to the analysis to correct for minor differential probabilities of achieving an interview based on age and gender. All research findings reported are based on weighted data. Percentages in the tables and quoted in the text are rounded to the nearest whole number, to avoid a spurious impression of accuracy. Due to this convention the column figures may, on occasion, sum to one percentage point more or less than 100.



## 2 Engaging potential Pathways Advisory Service users

This chapter looks at how patients in GP surgeries come into contact with PSAs and their motivations for attending the meeting with them. The first section presents data on how people learn about the Pathways Advisory Service, which shows that the GP plays an important role for most people. The next section, therefore, examines the referral practices of GPs. In the third section we compare the benefit status of Pathways Advisory Service clients with the intended target population, while the following section presents data on the diverse reasons why people go to see a GP. The penultimate section briefly looks at how appointments to meet the PSA are made.

### 2.1 How people learned about the Pathways Advisory Service

Although it was expected that referrals to PSAs would mostly come from GPs, it was also recognised that some patients attend GP surgeries for a variety of reasons other than to have a GP consultation, for example, to see nursing and other health professionals or to collect prescriptions or sickness certificates. Therefore, the surgeries in the pilot were encouraged to allow all staff (including reception and office staff) to tell patients about the Pathways Advisory Service and to make direct referrals to the adviser. Other forms of publicity were adopted in the early months of the pilot, such as information leaflets and posters, and other methods of advertising were introduced as the pilot progressed, such as attaching information to sickness certificates and prescriptions.

Table 2.1 is based on survey data and shows how people became aware of the PSA. A small number of respondents cited more than one source of information.

**Table 2.1 How people learned about the Pathways Advisory Service**

Source of information	%
GP	79
Other health practitioner	7
Nurse	4
Receptionist	3
Leaflet with repeat prescription	3
Leaflet picked up	1
Poster	1
Friend/family member	2
Other	8
<i>Weighted n</i>	211

Base: All respondents.

Note: Multiple responses permitted.

As the table shows, over three-quarters (79 per cent) of respondents said that they became aware of the PSA through their GP. Only a few people said they became aware of the service through a nurse (four per cent) or some other health practitioner (seven per cent).

PSAs talked about other methods that had been or were being, tried in surgeries to increase the flow of referrals and particularly to engage patients who do not physically see a GP but who might attend the surgery for repeat sickness certificates or prescriptions or who might receive correspondence from the surgery. The following examples were cited:

- Attaching some form of publicity material with sickness certificates and prescriptions.
- Writing to patients for whom the GP had received a request for a medical report for a repeat IB claim (the 'IB113').
- Publicising the Pathways Advisory Service through surgery newsletters, the DWP Pathways to Work website and the local media.
- Making presentations to groups of health professionals who might refer people (for example, community psychiatric nurses and counsellors).

In the early stages of the pilot none of these approaches had yielded more than the occasional referral.

In the research interviews with practice administrative and reception staff it was apparent that most people were happy to offer patients leaflets or to disseminate information in other ways but they were not comfortable with the idea of engaging patients in any sort of discussion about the Pathways Advisory Service or answering questions about it. Some commented that only a GP or other health professional

would have sufficient knowledge of the patient to be able to advise them to see a PSA. However, interviews with PSAs towards the end of 2007 suggested that referrals from receptionists, nurses and other practice staff had increased over the course of the pilot.

PSAs also emphasised how understandings of data protection law acted to constrain their attempts to advertise their service. They felt that it would be useful to have access to patient medical records and to combine this information with DWP records, in order to target advertising literature at people with long-term health problems who make infrequent visits to GP surgeries. However, this had not been permissible because medical records had not been compiled with this use in mind and because of uncertainties about the requirements of data protection legislation.

## 2.2 How GPs engaged their patients

In this section we draw on data from the first wave of GP interviews that took place in late 2006 and the second wave of interviews in late 2007. The GPs interviewed had generally had at least a year's experience of the pilot and some said they had adapted their practices over that time having learned 'what worked' in engaging patients.

It was evident that each GP took an individual approach in deciding who to tell about the Pathways Advisory Service and how they introduced the subject in their consultations. What emerged, therefore, was a variety of practices that GPs had found useful and methods of talking to patients that they found suited them, based on their understanding of which people were eligible for the service and their understanding of what the PSA could provide or what support they could help access. It should be noted, however, that some GPs' accounts of what the PSA could do did not match the 'gateway model' of delivery.

All of the GPs interviewed were aware that the Pathways Advisory Service was aimed at getting IB recipients back to work but most GPs did not interpret this as constraining them in who they told about the PSA. For these, there was an understanding that the PSA was available to give employment advice to a wider range of benefit recipients beyond only IB or wider still, to people who did not claim benefits at all. Although most GPs did not enquire about the benefit status of their patients, these different understandings of the purpose of the service tended to influence who GPs told about it.

There was also a wide understanding that the PSA could provide advice on social security benefits. This was viewed as extremely valuable by GPs. One GP explained that it was usually possible to have a meaningful conversation about a patient's health and their work, for example in discussing a return to work after a period receiving sickness certificates, but he did not have the knowledge to talk about benefits. Before the introduction of the pilot he found this limiting if a patient raised the subject of benefits as soon as he raised the subject of work. In the past he could only advise the patient to seek advice from Jobcentre Plus or a Citizens

Advice office and felt hindered in continuing to encourage the patient to return to work. In contrast, with the presence of the PSA, the subject of benefits was no longer a barrier as they could confidently tell patients that a benefits and employment 'expert' was working within the practice and that they could arrange for them to meet.

What GPs told their patients depended on their perceptions of what the PSA could offer. These varied quite widely and there was evidence that some GPs had an exaggerated sense of the influence of PSAs. For example, some GPs described patients getting quicker access to health care such as physiotherapy or cognitive behavioural therapy. These perceptions do not match PSAs' own description of the 'gateway model'. We consider the policy implications of this mismatch in Chapter 6.

All of the GPs interviewed said that they routinely introduced the subject of work (a) for patients who had had a number of sickness certificates, and (b) for people who had been out of work for long periods but whom they considered would be capable of, and benefit from, some form of work. There was a widespread view that being out of work was, over time, detrimental to people's mental and sometimes physical wellbeing. They were familiar with a pattern of behaviour in some people that gradually distanced them from the labour market. It should be noted again that the participating GPs were volunteers and thus, predisposed to supporting the principles of the pilot, such as seeing the need to talk to patients about work. Other GPs may have different opinions about the value of work for the wellbeing of their patients.

It was interesting that GPs had developed their own discursive practices that they employed to encourage people to think about work. A commonly used question was '*have you thought about work?*' which GPs said could open up opportunities for introducing the idea of seeing the PSA. However, some GPs found that after a negative response to this question it was sometimes difficult to make further progress and had developed different ways of introducing the topic of work. For example, one GP asked appropriate patients '*do you want to work?*' and another asked '*what sort of work would you ideally like to do?*'. Both found that their questions usually generated positive answers and at some point in the subsequent conversation an opportunity would arise to introduce the services of the PSA.

Many GPs interviewed commented on the influence on their patients of saying that the PSA could advise on the effect of working or other activity on their benefits, could provide a benefit check (that might reveal eligibility for other benefits) and had access to other forms of financial assistance. For some patients access to financial advice seemed to the GP to be more influential than mentioning employment advice.

Most GPs talked about their ability to be persuasive in talking to patients about the PSA but were clear that it would be counterproductive to try to 'push' patients further than they wanted to go. Some GPs said they might put a note on the

patient's record to mention the PSA at a later date if they had seemed uninterested or reluctant initially.

There were different views about whether GPs should tell patients that the PSA was an employee of Jobcentre Plus. Over the course of the pilot some GPs who had initially told patients that the adviser was from 'the Jobcentre' had ceased doing this. They reflected that they saw the PSA as very much part of the practice team and wanted to emphasise this to patients rather than possibly put off people by telling them about the Jobcentre Plus connection. They saw this approach as pragmatic because they were aware of the preconceptions and prejudices that many people, including their patients, might have about Government organisations in general and Jobcentre Plus in particular.<sup>4</sup>

In the first round of interviews with GPs in 2006, it was noteworthy that many GPs talked about how they were initially selective in who they referred to the PSA, tending to refer patients who were close to getting back to work. Some mentioned, however, that they had been influenced by some unexpected 'success stories' and were beginning to refer more patients who initially they felt were unlikely to get work. By the time of the second wave of interviews GPs said that their own views about a person's employability were now much less of a factor in their decisions about who to tell about the PSA. They had learned that however far from the labour market someone might seem was not necessarily an indicator of their likely success in finding work.

Several GPs said that over the course of the pilot they had developed a growing confidence and trust in the PSA, particularly in their interpersonal skills. This was important because they felt they could then recommend the PSA honestly and genuinely and in doing so would not put at risk the doctor-patient relationship that was essential to them.

One further aspect of the pilot that GPs valued was the physical presence of the PSA in the surgery. This made referral very easy for them. They could either take patients to the PSA immediately or make an appointment with the reception staff. Some GPs wrote a note to the PSA to ask them to contact the patient. GPs emphasised that the lack of formal, written referral procedures was useful. They felt that any additional paperwork would in practice discourage them from making referrals.

Interviews with PSAs confirmed that the types of patient referred to them were very diverse, although there were few people to whom they felt they could not offer some sort of constructive advice. The next section further confirms this diversity using data from the survey.

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<sup>4</sup> We shall see in Chapter 3 that PSAs themselves are generally open with people about their employment by Jobcentre Plus.



### 2.3 Benefit and employment status of referred patients

As mentioned in Chapter 1, the Pathways Advisory Service was designed to be open to anyone but the aim was to attract people in receipt of SSP and long-term recipients of IB. Table 2.2 summarises the benefit receipt of the survey sample.

**Table 2.2 Benefit receipt at time of meeting with a Pathways Support Adviser**

<b>Benefit</b>	<b>%</b>
IB	29
SSP	10
Income Support	27
Housing Benefit	21
Council Tax Benefit	24
Disability Living Allowance	14
Jobseeker's Allowance	8
Child Benefit	4
Working Tax Credit	7
Child Tax Credit	7
Other benefit	3
No benefits	22
<i>Weighted n</i>	210

Base: All respondents.

Note: Multiple responses permitted.

**Table 2.3 Employment status at time of meeting with a Pathways Support Adviser**

<b>Employment status</b>	<b>%</b>
In paid work	5
Temporarily off work	16
Looking for paid work	8
Voluntary or unpaid work	1
In training	1
Caring role/looking after home	8
Sick or disabled, not attached to work	59
Retired	1
<i>Weighted n</i>	212

Base: All respondents.

Note: Multiple responses permitted.

There are different ways of interpreting these tables: Firstly, it might be concluded that the pilot has not been performing well in reaching its principal target population of IB and SSP recipients, given the low percentage of people who were receiving these at the time of their meeting with a PSA. However, 16 per cent of the sample said they were temporarily off work, suggesting that there is some demand for job retention advice from PSAs. It is possible to argue that the desire for employment and other advice extends beyond the IB and SSP populations and that, therefore, the Pathways Advisory Service is reaching a new, interested group of people who might not otherwise have contact with Jobcentre Plus services. The range of benefits is also a likely reflection of GP referral practices. As we have seen already, GPs generally did not ask their patients about benefit status but chose to tell them about the PSA if they thought they could benefit from employment or benefit advice.

Further analysis of the responses suggests that people with mental health conditions who see a PSA are less attached to the labour market than people with physical conditions. For example, seven per cent of people with mental health conditions were off work temporarily compared with 21 per cent of the rest of the sample, and 72 per cent said they were 'off sick' and not connected to work compared with 50 per cent of other people.

## 2.4 Reasons for meeting a Pathways Support Adviser

Survey respondents were asked about their reasons for wanting, or agreeing, to see a PSA. Table 2.4 presents a breakdown of the responses. (It should be noted that multiple responses were permitted.)

**Table 2.4 Reasons for seeing a Pathways Support Adviser**

<b>Reason</b>	<b>%</b>
Health	56
Moving into work	43
Benefits	37
Training	19
Financial situation	17
GP suggested it	13
Current job	9
Partner's work/health/benefits	5
Other	6
<i>Weighted n</i>	212

Base: All respondents.

Note: Multiple responses permitted.

The table shows the wide range of reasons cited by the survey respondents which possibly reflects (a) the different ways in which GPs attempted to interest their patients in seeing the PSA and (b) the diverse range of information and advice needs that the patients had themselves.

Although many people gave more than one reason for wanting to see a PSA, it was possible from the data to distinguish between those who wanted to discuss something about moving into employment (including people who were interested in training) and people who had other reasons not related to work. Table 2.5 presents the results of this analysis.

**Table 2.5 Relevance of work in reason for wanting to meet a Pathways Support Adviser<sup>5</sup>**

Reason	%
Work-related	51
Not work-related	49
<i>Weighted n</i>	213

Base: All respondents.

There were no differences between men and women in the reason for wanting to see a PSA but there were differences according to the ages of the respondents. Table 2.6 shows that younger people cited a work-related reason more than the older age groups.

**Table 2.6 Main reason for wanting to meet a Pathways Support Adviser by age band**

Main reason	16-34 %	35-44 %	45-54 %	55+ %	All %
Work-related	61	51	43	39	51
Not work-related	39	49	57	61	49
<i>Weighted n</i>	76	57	47	28	208

Base: All respondents.

From the qualitative follow-up interviews it was apparent that some people were unclear about what they expected from the PSA meeting. There was evidence that a number of people felt under pressure to attend the meeting with the PSA. (Table 2.3 shows that 13 per cent of the survey sample said they saw the PSA because 'the GP suggested it'.) For example, some said that they only attended because they thought that they needed to in order to receive SSP or benefits or that they felt

<sup>5</sup> Respondents were permitted multiple responses. Anyone who mentioned a work-related reason at all (including those who mentioned other reasons for seeing the PSA) were included in the 'work-related' category in Table 2.5.

obliged because their GP or practitioner had suggested it. There was also a group of people who felt that they had not been given enough information by their GP about the purpose of the meeting prior to attending and who consequently felt that they had not consented to the meeting in an informed way. For example, one person said that she believed that she was going to see a nurse about her blood pressure and would not have attended the meeting if she had known it was about a return to work. These examples demonstrate the need for clear information from both the referring practitioner and the PSA and opportunities for people to opt out.

## 2.5 Making the Pathways Support Adviser appointment

Table 2.7 shows who made the appointment with the PSA. In almost two-fifths of cases (59 per cent) the GP took responsibility for arranging the appointment. In 16 per cent of cases the receptionist arranged the appointment and 14 per cent of appointments were arranged by the respondent directly with the PSA. Only two per cent did not have an appointment and dropped in.

**Table 2.7 Who arranged appointment with the Pathways Support Adviser**

Who arranged appointment	%
GP	59
Receptionist	16
Respondent – directly with PSA	14
Other health practitioner	7
Nurse	1
Not arranged – dropped in	2
<i>Weighted n</i>	208

Base: All respondents.

We know from the interview data from GPs that they are able to, and do in practice, refer some patients directly and immediately to a PSA.

Some people saw PSAs on the same day, while they were attending the surgery. The evidence from the follow-up sample suggests that this was mainly welcomed, although some people were critical. The advantage of this was that the appointment took place promptly and at a time and place that was, on the whole, convenient for them. However, some said that they did not have sufficient time to consider participation in the meeting. In other cases an appointment with the PSA was arranged for a later date, for example, because the PSA was not in on the day of the doctor's appointment, because they already had bookings or because 'that's how it works'. In these cases, the PSA spoke to the prospective client while they were at the surgery, or later by telephone, in order to arrange a convenient time for them to return to the surgery. Where people were given information about

the service they were asked to call in if they wanted to make an appointment. The advantages of arranging an appointment at a later date or by calling in was that it allowed more time to consider whether the appointment was appropriate for them and to prepare. It also meant they could bring information to the meeting that was pertinent to their concerns, such as letters about their medical condition or benefit information.

## 2.6 Conclusion

It was expected that the GP would play an important role in facilitating a meeting between a patient and a PSA and the findings presented in this chapter have confirmed and emphasised the pivotal role that they play. Four in five referrals to the PSA came from the GP. However, there was also evidence that referrals from other practice staff had grown over the course of the pilot.

The evidence on the approaches taken by GPs to engage patients and what they find effective, could be useful in disseminating 'good' practice when the Pathways Advisory Service is expanded in 2008 (as mentioned in Chapter 1). It is interesting that only half of the people who went on to see a PSA had work in their thoughts initially. However, as we shall see in Chapter 3, many of those who went for reasons not related to work did engage subsequently with some form of work-related activity. This suggests that GPs should not be discouraged from recommending people to see a PSA even if they initially appear not to be interested in work.

There appears still to be a number of people with long-term health problems whom the GP does not see in person but for whom employment advice might be appropriate and welcome. Some more creative thinking in this area or greater resources are perhaps needed in order to access this group further.

The evidence that younger people tend to be more interested in work than older age groups is also interesting. On the one hand it is encouraging that younger people are taking up the opportunities available through the PSA to move towards work. On the other hand the finding perhaps emphasises the difficulty in motivating and mobilising older workers who are already disadvantaged in the labour market.

The survey results show that very few SSP recipients had used the Pathways Advisory Service. One contributory explanation for this appears to be the referral practices of GPs some of whom did not appear to appreciate that people in work are equally eligible for, and might equally benefit from, employment and financial advice. It seems appropriate therefore to re-emphasise the scope of the Pathways Advisory Service as a job retention service.

The physical presence of the PSA in the surgery was clearly important to GPs and an immediate meeting with a PSA worked well for most people who had one. Some patients, however, did feel either pressured or unprepared when they met the PSA on the same day as the GP consultation.

# 3 Content and outcomes of meetings with Pathways Support Advisers

This chapter draws on the survey data, qualitative follow-up interviews with surgery patients and interviews with PSAs to explore the content and outcomes of meetings between them. We firstly present data on the wide range of topics that were discussed in meetings and the suggestions that PSAs made to people after those discussions. Using the distinction introduced in Chapter 2 between people who went to see a PSA for work-related reasons and those who went for other reasons, we will examine the extent to which PSAs were able to orient discussions towards work for both groups.

We then present survey data on how useful people found the meetings and draw on qualitative data to explore what aspects of the meetings were particularly helpful. The follow-up interviews are also the source for identifying the dissatisfaction that some people expressed about the content and outcome of their meeting with a PSA.

## 3.1 The form and content of Pathways Support Adviser meetings

In all of the pilot areas PSAs said that they had no rigid format (or 'script') for talking to patients. They might begin by asking general questions about the person and their family and develop the conversation according to how people responded. In general most conversations covered the client's health, family background, employment history, education and qualifications. At some point the PSA would usually mention that they were from Jobcentre Plus. PSAs rarely had any knowledge in advance about a client. Some had attempted to introduce some type of referral form for the GP to complete but these were rarely, if at all, used.

PSAs reported that most people came to the meeting wanting to talk about either work, benefits or health but usually a combination of these. Meetings were almost always constructive, although occasionally people had apparently only attended the meeting because the GP had suggested it. The PSAs had all adopted ways of responding to often negative perceptions that people brought to meetings about their ability to work. One PSA mentioned that her training as a Pathways to Work adviser had helped her talk to people in a way that initially focused on future aspirations and possibilities rather than immediate problems and difficulties.

The interview data from PSAs was reflected in the data from the survey sample. Table 3.1 shows responses to the question of what was discussed at the initial PSA meeting. The responses are broken down by whether the patient saw the PSA for a work-related reason or not.

**Table 3.1 Topics discussed at first meeting, by main reason for seeing PSA**

Topic	Main reason for seeing PSA		All %
	Work-related %	Not work-related %	
How health affects work	70	61	66
Type of work might do	66	36	52
Building confidence to work	51	28	40
How might apply for jobs	47	17	32
Partner's work	6	9	7
How partner might find work	5	1	3
How to manage health	56	55	55
Partner's health	6	8	7
Benefits	62	52	57
Financial situation	48	34	41
Other	3	3	3
<i>Weighted n</i>	109	102	212

One interesting feature of this table is the volume and range of topics that PSAs covered in the course of a single meeting. In particular it is noticeable how many work-related topics were raised in meetings with people who did not go to see the PSA for a work-related reason. Six in ten meetings covered how health affects work and over one in three included a discussion about what type of work the person might be able to do. Among those who did want to discuss work-related topics nearly half had progressed to talking about applying for jobs.

As noted in Section 2.3 the survey respondents who had mental health conditions were more detached from the labour market than people with physical and other conditions. However, this did not appear to have much of an impact on the content

of discussions with PSAs. The only difference between the two groups was that 53 per cent of the sub-sample with a mental health condition had discussed 'building confidence to work' compared with 32 per cent of the rest of the sample.

People in the follow-up sample were also asked what they could recall of their meeting with the PSA. Their responses add more depth to the survey results. Topics that people described being discussed also reflect the interviews with PSAs. PSAs emphasised the need to know about both someone's health and their work situation before they could decide what information and advice to tell them or what referrals might be appropriate. Topics discussed included:

- general discussion of health situation and circumstances;
- discussion or reassurance about whether the person was receiving the correct benefits;
- general discussion about the employment history and discussion about the possibility of returning to work in the future;
- encouragement for people with mental health problems to increase social participation, for example, by joining an adult education class;
- provision of information about the range of help and support available through Pathways to Work and Jobcentre Plus;
- where appropriate, referrals on to other Jobcentre Plus or Pathways provision, sometimes including the creation of a specific action plan;
- occasionally, arrangements for a second meeting or follow-up telephone call.

One reason why so much ground could be covered in PSA meetings was that PSAs were not limited in the amount of time they spent with people. Table 3.2 shows the survey respondents' estimates of how long their initial meeting lasted.

**Table 3.2 Length of first meeting**

<b>Length of meeting</b>	<b>%</b>
< 15 minutes	7
15 to 30 minutes	46
> 30 minutes	47
<i>Weighted n</i>	211

Base: All respondents.

PSAs commented that one of the advantages of their role as a PSA compared with other roles held within Jobcentre Plus, was not only the lack of restrictions on the amount of time they could spend with people but also the absence of any targets that might influence how they handled meetings.



### 3.2 Outcomes of meetings with Pathways Support Advisers

It is worth noting that some PSAs in the study mentioned that they had seen people who were already part of the Pathways to Work programme in some way. Some were part way through their WFI regime or awaiting their first interview but PSAs still thought their meeting was useful as a way of reassuring people about Pathways as a scheme that was designed to help them. Others had 'been through' Pathways previously and were now long-term recipients of IB. Meetings with these people could be very productive in re-engaging them with thinking about work and linking them up with Pathways again if appropriate.

In talking about the type of suggestion that they might make to patients, PSAs listed a wide range of support options, including:

- Jobcentre Plus advisers (including Pathways to Work advisers, lone parent advisers and Disability Employment Advisers);
- CMP;
- Job Brokers;
- WORKSTEP;
- Work Preparation;
- Connexions service for young people;
- advice organisations (such as Citizens Advice, local authority welfare rights);
- community organisations and projects (including a women's centre, job club, drugs project);
- education providers (local colleges);
- Government departments (such as the Border and Immigration Agency).

PSAs emphasised that most of their referrals were to Jobcentre Plus or the CMP but their knowledge and experience of working in Jobcentre Plus gave them an extensive knowledge of other externally-provided services available locally, even though these were used much less frequently.

PSAs reported that discussions with people about their benefit status often resulted in advice (and help) to claim a different or an additional benefit. It was interesting that PSAs all referred to occasions when they had advised someone to claim IB (sometimes instead of Jobseeker's Allowance (JSA)) in order to (a) be eligible for the range of provision available as part of Pathways and (b) to remove the immediate pressure to seek work when they felt that making a more gradual return to work was appropriate.

The findings from the survey largely matched the interview data from the PSAs. Survey respondents were asked to look at a pre-coded list and say what

suggestions or recommendations were made to them by PSAs. Table 3.3 presents their responses broken down by the main reason people wanted to see a PSA.

**Table 3.3 Suggestions from PSA, by main reason for seeing PSA**

Suggestion from PSA	Main reason for seeing PSA		All %
	Work-related %	Not work-related %	
Meet with adviser at Jobcentre Plus	65	44	55
Join CMP	35	46	40
Work-related training	25	12	19
Register with Job Broker	14	8	11
Work trial	9	3	6
Wait for health to improve	25	13	20
Go back to doctor	16	10	13
Change benefits	17	23	20
See advice organisation	10	9	10
Something else	2	2	2
Nothing suggested	3	7	5
<i>Weighted n</i>	<i>108</i>	<i>99</i>	<i>206</i>

Base: All respondents.

Note: Multiple responses permitted.

As we have noted earlier, PSAs' principal referral route was to a Jobcentre Plus adviser. This is reflected in the table, which shows that 65 per cent of people interested in work were referred in this way. PSAs commented that for some people such a referral was not appropriate immediately because their health needed to improve first or they needed to change benefits. It is also interesting that nearly half of patients who did not go to the PSA to talk about work received a suggestion either to go to a Jobcentre Plus adviser (44 per cent) or the CMP (46 per cent).

A comparable analysis by health condition shows that PSAs made fewer referrals to a Jobcentre Plus adviser for people with mental health conditions compared with the rest of the survey sample (39 per cent compared with 65 per cent respectively). However, they appeared to make slightly more suggestions to those with mental health conditions that we might call 'intermediate', such as referrals to a CMP (44 per cent and 37 per cent respectively) and suggestions to wait until health improves (25 per cent and 17 per cent respectively).

The evidence from the follow-up interviews was similar to the survey. Most referrals were to Pathways to Work advisers though referrals to a Disability Employment Adviser were also identified as suggestions made by PSAs. Respondents also

referred to signposting and referrals to other provision, such as direct referrals to the CMP, Job Brokers, occupational health or health management services and organisations offering advice and support for disabled people such as the Disability Rights Commission.

From the interviews with PSAs and the follow-up sample it was apparent that PSAs did not only make suggestions to people but would, with their agreement, often make appointments on their behalf, particularly to Jobcentre Plus staff, but also to a CMP or Job Broker. Some PSAs said they would only do this if the person was in a 'desperate' state, for example, getting away from domestic violence. In making contact with Jobcentre Plus advisers, PSAs sometimes indicated which particular services or forms of support they felt would benefit the patient.

Chapter 4 presents analysis from the survey data of the extent to which suggestions made by PSAs were followed up.

### 3.3 Usefulness of meetings with Pathways Support Advisers

In this section we draw on survey findings and the follow-up interviews. In the survey respondents were asked to assess the overall usefulness of their initial meeting. Their responses are presented in Table 3.4.

**Table 3.4 Overall helpfulness of meeting**

Level of helpfulness	%
Very helpful	46
Quite helpful	45
Not very helpful	6
Not at all helpful	2
<i>Weighted n</i>	212

Base: All respondents.

In comparison with comparable findings from evaluations of the NDDP (Stafford *et al.*, 2007) and Pathways to Work (Bailey *et al.*, 2007) these are high levels of satisfaction. As Table 3.4 shows, in the pilot, 91 per cent of survey respondents rated their meeting with a PSA as either 'very' or 'quite' helpful. The NDDP evaluation had several waves of user surveys in which between 51 and 62 per cent of respondents rated the Job Brokers as helpful. The evaluation of the initial phase of Pathways to Work included a survey question about the helpfulness of the regime of WFIs. Findings were broken down by each of the seven pilot areas. The percentages of respondents who found the WFIs helpful ranged between 59 per cent and 77 per cent.

As a way of exploring, in more depth, the quality of their experience in meeting a PSA the survey also included a question asking respondents the extent to which they felt PSAs were listening to them. Table 3.5 presents the results.

**Table 3.5 Extent to which PSA was listening**

Column	%
Very well	78
Fairly well	19
Not very well	3
Not at all well	1
<i>Weighted n</i>	212

Base: All respondents.

Again, this result compares favourably with the findings from the Pathways to Work evaluation in which 63 per cent of people who had attended a WFI thought that the personal adviser had listened 'very well' (Bailey *et al.*, 2007).

When survey respondents had taken up the suggestion to see a Jobcentre Plus adviser they were asked specifically whether this particular suggestion had been helpful. Table 3.6 presents their responses.

**Table 3.6 Helpfulness of suggestion to see Jobcentre Plus Pathways adviser**

Level of helpfulness	%
Very helpful	54
Quite helpful	38
Not very helpful	6
Not at all helpful	2
<i>Weighted n</i>	76

Base: Respondents who took up suggestion to see Jobcentre Plus adviser.

As Table 3.6 shows most people who had taken up the suggestion to see a Pathways to Work adviser in a Jobcentre Plus office found the suggestion helpful (92 per cent).

### 3.4 How people found Pathways Support Adviser meetings useful

In the follow-up interviews people discussed a range of ways in which contact with a PSA was useful to them, independent of any onward referral or signposting

to other provision. In particular, they referred to the role of the PSA in encouraging and motivating them to consider a return to work, in clarifying employment options, in providing advice about benefits and permitted work and in informing them about help and support that might be available to them. This section uses detailed examples to illustrate how people in different circumstances found the meetings helpful.

### 3.4.1 Encouraging thinking about work

A number of people described contact with a PSA as being a catalyst, motivating them to undertake work-focused activity or to seek work. They said, for example, that the meeting with the PSA had given them a 'kick start', that it helped to get the 'ball rolling' or gave them 'a push'. These people said that they would have been unlikely to have taken steps towards work or proactively sought any work-related support without the input of the PSA. For some people who had come to believe that employment was not an option for them, being referred to a PSA and the confidence of the PSA in the possibility of them moving towards work, increased their own confidence and encouraged them to believe that work was actually a possibility for them. This group of people included those with physical disabilities, for example, a person experiencing the effects of a stroke and another person with speech problems. It also included older people. In one case, for example, a woman in her 50s had considered 'retiring on medical grounds' prior to contact with the PSA. Being offered a referral to a Disability Employment Adviser at Jobcentre Plus made her feel that work was still a possibility. In another case, a person with mental health problems, who had later started a training course as a result of meeting with a PSA, said that she had found the adviser encouraging and that it was helpful to be told that she could take small steps at a time on the way back to work, rather than having to find work immediately.

Table 3.7 shows that the majority of the survey sample said they had been helped to think about work either 'a lot' or 'a little' (82 per cent). Furthermore, over two-thirds (70 per cent) of the people who did not have a work-related reason for seeing the PSA said they had been helped in this way.

**Table 3.7 How much meeting PSA helped thinking about work, by main reason for seeing PSA**

Extent of helpfulness	Main reason for seeing PSA		All %
	Work-related %	Not work-related %	
A lot	57	34	46
A little	35	36	36
Not at all	7	30	18
<i>Weighted n</i>	108	103	211

Base: All respondents.

### 3.4.2 Clarifying employment options

People described how they had welcomed the opportunity to talk generally through their employment options in the context of their health. They valued the fact that the PSA could give them more time than their GP and that they could provide a more objective perspective on their situation than their employer, family or friends. Sometimes this could mean helping the person to decide that a return to work was not the right option for them immediately or in the short-term. For example, a woman with a mental health condition described how she had not felt ready for a return to work but was feeling pressured by her employer and her husband to do so as quickly as possible. In this case, the PSA had, following discussion of her recent employment history and ill health, suggested that it probably was not appropriate for her to return to her old job if it was contributing to her health problems. The PSA told her about the support options available but, according to the respondent, the PSA had said that it would be more appropriate for her to consider them when she felt *'mentally prepared to do a job'*.

For people who had recently received diagnoses, or could not return to their old job because of their health condition, the PSA could also help to clarify what types of work they could do and to point them in the right direction for retraining where necessary. For example, a person with multiple sclerosis said that meeting with the PSA helped him to realise that he was not able to return to his previous job because of the physical demands it made on him and that he needed to think about seeking a less physically demanding job. The PSA referred him to a Disability Employment Adviser who then helped him access training to improve his English, Maths and IT skills as preparation for seeking less strenuous employment.

### 3.4.3 Providing advice about benefits and permitted work

Gaining reassurance and advice about eligibility for benefits and information about permitted work rules were cited as useful outcomes of contact with a PSA. People said that their PSA had offered them reassurance about whether they were receiving the correct benefits, information about in-work financial help such as Working Tax Credit (WTC) and information and advice about permitted work. People said that this had helped clarify the financial implications of a return to work and helped to reduce their financial problems and concerns. For example, one person with a mental health condition described how she had found out about permitted work through meeting with a PSA and how she had subsequently taken up part-time work as a result. Another person, who had a physical condition and who was also caring for his wife, said that he had never claimed benefits before and that he had been *'running around in circles'* until he met with the PSA.

### 3.4.4 Providing information about help and support

A number of people said that they had gained access to information, advice and support that they would otherwise not have known about, without seeing the PSA. People said that they had been made aware by their PSA of support such as Pathways to Work, Disability Employment Advisers, Work Preparation, the CMP, Job

Brokers and the advice services of the Disability Rights Commission. Additionally, another group of people said that, although they were already aware of these provisions to some extent through prior contact with Jobcentre Plus, contact with a PSA had helped to reduce their confusion about the array of options available to them. One person who had felt particularly confused about the help and support on offer said that it had really helped to go through the different options available to him in detail, describing it as being like *'somebody throwing out a life-buoy to you when you are in the sea'*. People's actual experiences of receiving onward help and support are discussed in Chapter 5.

### 3.5 Dissatisfaction with the Pathways Advisory Service

As we have seen in Section 3.3 most people found their meeting with the PSA useful and Section 3.4 drew on the data from the follow-up interviews to elaborate how the meetings helped them. However, not everyone had positive experiences (Table 3.7 shows that eight per cent did not find meeting the PSA helpful) and we were able to explore criticisms in the follow-up sample. Again, detailed examples are used to show how and why some people did not find the PSA meeting helpful.

#### 3.5.1 Perceived lack of support

Some people felt that the PSA had failed to offer them further support even though they wanted to move towards work. Commonly, these people had more serious health conditions such as terminal illness, severe disabling conditions or enduring mental health conditions such as bipolar disorder. These people tended to interpret the lack of support offered as the PSA seeing them as unemployable and this could undermine their confidence and self-esteem. For example, one person with terminal cancer was told that if she wanted to seek work she should undertake job searches at Jobcentre Plus herself and no other suggestions or referrals were made. She felt that the PSA had assumed that she would not be able to find work and had, therefore, not offered her any support. To some extent these criticisms may reflect people's perceptions of the role of the PSA as being more than the 'gateway' service that they could, or were meant to, offer.

#### 3.5.2 Unhelpful suggestions

In some cases people had discussed options with their PSA but had discounted them because they felt there was a lack of fit between the support offered and their needs. A person with a mental health condition, for example, said that she felt very disappointed with the support offered during the meeting with her PSA. Although the PSA discussed the CMP and general work options in relation to her existing qualifications and skills, she felt that nothing specific had been offered that involved clear next steps to help her look for a job. In another example, a person felt suggestions of help for re-employment were inappropriate because he was still in receipt of SSP from his current employer. In another case, a person who had worked in a professional role prior to experiencing the acute onset of a

mental health condition, and who had numerous qualifications, felt that he did not need the support of a Job Broker because he was capable of compiling a CV and searching for jobs himself.

Some people with mental health and musculo-skeletal conditions said that they had considered the CMP but felt that it would not help them because they already understood their condition and were already managing their health successfully. Other people said they rejected the CMP because they did not have confidence in the service. For example, one person suffering from a musculo-skeletal condition and mental health problems said that she had turned down the offer of joining the programme because she had no confidence in a service run by the NHS due to previous negative experiences. Another person said that her decision not to join a CMP was influenced by her understanding of the experiences of people who had attended an NHS group for people with her condition but had not gone back to work.

There were people on various benefits who said that PSAs had provided them with confusing or incorrect advice about their eligibility for IB. For example, one person thought that he had been put to considerable inconvenience after being encouraged by his PSA to apply for IB and then finding that he had not made sufficient National Insurance (NI) contributions to be eligible. In another case, a woman had been told by Jobcentre Plus staff that she was ineligible for IB but was unclear why and asked the PSA to provide clarification. However, she said that she was left more confused about why she was not eligible after seeing the PSA than she had been from previous discussions with Jobcentre Plus staff. While such experiences did not always prevent people from benefiting from contact with the PSA, for example, through the take up of onward referrals, it did tend to undermine their confidence in the knowledge and expertise of the PSA.

### **3.5.3 Information incomplete, inaccurate or confusing**

Some people also felt they had received incomplete advice from their PSA. For example, a person who had retired early in his mid-50s and was in receipt of a pension from his employer following an accident at work, felt that the PSA had been unable to answer his questions about whether he was able to work while continuing to receive a pension related to his injury. Another person thought that her PSA had failed to tell her about employment opportunities for people in receipt of IB through her local county council, which she had later discovered in a newspaper article. While it was unclear whether this provision was part of the local Pathways provision, the fact that such options were available meant that she felt she had been given incomplete information and advice.

Exceptionally, people said that they were confused by the PSA's explanations of available support. One person, for example, suffered from poor concentration and said that PSA had gone through information about training options too quickly. It was not clear whether this confusion was conveyed to the PSA but no further meetings or referrals were arranged and the person did not take up any of the options discussed.



### 3.6 Conclusion

It is apparent from the evidence presented in this chapter that PSA used their meetings with surgery patients to discuss a wide range of topics not all of which were about getting back to work. Nevertheless, work-related topics were widely covered, including in meetings with people who did not initially attend the meeting for a work-related reason. Furthermore, the evidence that the outcome of many meetings included suggestions that might contribute to a route back to work, in the short-, medium- or long-term, show that an interest in work could be developed constructively even among people who did not express an initial desire to get into work.

The further evidence on the proportion of people who found their meetings helpful suggests that PSAs are tailoring the content and conduct of meetings well to suit people's individual needs.

The data from the follow-up interviews with Pathways Advisory Service users suggests that many people were able to learn about aspects of welfare to work provision (including employment help and benefit information) that they previously did not know or were reluctant to pursue themselves.

The evidence from people dissatisfied with their PSA meeting has a number of implications: First, it reinforces the importance of good communication skills for PSAs. Some people in the study appeared to have an exaggerated sense of what the PSA can do or offer. The data also suggest that referrals to the more commonly used services such as Jobcentre Plus Pathways advisers, CMP or Job Brokers are not always appropriate, for example to people with high levels of qualifications or professional experience.

## 4 Further activity after the Pathways Support Adviser meeting

In this chapter we explore what happened to people after their meeting with a PSA in their GP's surgery. First we draw on the survey data to examine what people did in the short-term (i.e. in the three months or so between meeting a PSA and the research interview) and whether, and how, their employment and benefit status had changed in this time. We then draw on the follow-up interviews with 45 of the original sample to examine their experiences of further provision and any longer-term changes in circumstances. Using the follow-up data we also explore people's longer-term perceptions and reflections on whether the suggestions and referrals from PSAs were appropriate and useful.

The final two sections of the chapter also draw on the follow-up interviews to look at the influences people's subsequent activity had on their moves towards and into work and at the barriers faced by people who were still not in paid work.

### 4.1 Responses to suggestions from Pathways Support Advisers

In Chapter 3 we presented data on the content of the meetings between patients and PSAs and the range and number of suggestions made by the latter. In Table 4.1 we show the extent to which these suggestions were taken up and acted on by the survey sample.

**Table 4.1 Suggestions carried out by time of research interview**

Suggestion	Main reason for seeing PSA			
	Work-related		Not work-related	
	Suggested by PSA N	Done N	Suggested by PSA N	Done N
Meet with adviser at Jobcentre Plus	70	43	43	33
Join CMP	38	19	45	26
Work-related training	27	2	12	0
Register with Job Broker	15	8	8	3
Work trial	10	0	3	0
Go back to doctor	17	13	10	8
Wait for health to improve	27	22	13	10
Change benefits	18	12	23	13
See advice organisation	11	5	9	5
Something else	2	2	2	0
Nothing done	3	27	7	31

It is important to note that the responses related to the time of the research interview only. It is unknown, therefore, how many more of the suggestions made by PSAs were eventually acted on. We must also be cautious in interpreting the table given some of the small cell values. Nevertheless, some observations can be made. Excluding the 'passive' suggestions to go back to the GP or await improvements in health, the table shows that there were 336 suggestions connected to moving towards work made by PSAs, of which, 171 had been acted on by the time of interview (51 per cent).

Among the whole sample, 113 suggestions to see a Jobcentre Plus adviser were made, of which, 76 had been followed up by the time of the survey interview (67 per cent). However, we should also note of the 37 people in the survey who had been advised to see an adviser at Jobcentre Plus but had not done so, 24 (65 per cent) said they were planning to do so in the future. The table also shows that the follow-up rate of people who had not initially gone to see a PSA to talk about work was actually higher than those who did have a work-related reason for seeing the PSA – 77 per cent (33 out of 43) and 61 per cent (43 out of 70) respectively. This finding suggests that the Pathways Advisory Service is activating a group of people who were not thinking about work when they saw their GP but who subsequently saw an adviser in Jobcentre Plus (and therefore, could potentially connect with the wider range of services available through Pathways). Take up of CMP suggestions is slightly less than for Jobcentre Plus meetings but still over half (54 per cent).

The table presents a more negative picture about the follow-up rates for work training or work trials. However, training and trials will take considerably more time to set up than meetings with Jobcentre Plus advisers or CMP practitioners, requiring intermediate contact with Jobcentre Plus staff or Job Brokers for example. The findings from the survey, therefore, need to be interpreted with some caution.

Again, because of the timing of the survey interviews it is hard to interpret the numbers of people who had 'done nothing' since seeing the PSA (28 per cent of the full sample). Some respondents had said for example that the PSA had not suggested anything in the first place. There is some data, however, from the follow-up qualitative interviews that sheds light on why people do not take up suggestions from PSAs.

## 4.2 Short-term experiences and outcomes – changes in status at time of survey interview

Survey respondents were asked whether there had been any change in their work or benefits situation since the first meeting they had with the PSA. As Table 4.2 shows, in one-fifth of cases (20 per cent) people had changed their benefits and in ten per cent of cases their work situation had changed, although the outcomes seen here cannot necessarily be attributed to the impact of the programme and may have occurred anyway.

**Table 4.2 Changes to work or benefits**

Column	%
Work changed	8
Benefits changed	18
Work and benefits changed	2
No	73
<i>Weighted n</i>	211

Base: All respondents.

Of those whose work situation had changed 11 (59 per cent) had moved into paid work, two were doing a work trial, two were looking for work and four had come off work temporarily. The work situation at time of interview is shown for all respondents in Table 4.3. A total of seven more people were in work than were at the time of first meeting the PSA. There were very few changes otherwise.

**Table 4.3 Work situation at time of interview**

<b>Employment status</b>	<b>%</b>
In paid work	9
Temporarily off work	15
Looking for paid work	8
Voluntary or unpaid work	1
In training	2
Caring role/looking after home	7
Sick or disabled, not attached to work	57
Other	1
<i>Weighted n</i>	<i>211</i>

Base: All respondents.

Note: Multiple responses permitted.

### 4.3 Longer-term experiences and outcomes

In Chapter 3 it was noted that referrals were made by PSAs not only to Jobcentre Plus personal advisers but also to Disability Employment Advisers. Both personal advisers and Disability Employment Advisers provided advice on benefits and permitted work and supported people to apply for benefits such as Disability Living Allowance (DLA) and Carer's Allowance. They also provided support with job search and training options and were able to access a range of financial support for people wishing to undertake training as well as organise voluntary work placements. On some occasions, advisers suggested contacting Citizens Advice for legal advice on benefit matters and local authority social services departments and disability rights organisations. People in the follow-up sample had also been referred to the CMP, work psychologists, Job Brokers and Work Preparation schemes, employer-provided occupational health services and a range of health management focused courses (such as a 'life balance' course designed to help reduce anxiety) and various forms of education and vocational training.

Where people were signposted or referred on to other provision, either directly by PSAs or subsequently by Jobcentre Plus advisers and Disability Employment Advisers, this was usually considered to have been appropriate and helpful, although there were exceptions where people experienced difficulties.

#### 4.3.1 The appropriateness and value of referrals

PSAs commonly referred people to Jobcentre Plus staff; personal advisers and Disability Employment Advisers specifically. These staff sometimes provided various forms of support directly as well as making onward referrals or signposting to other services and support. Less commonly, PSAs would signpost or make direct referrals to other services. What people reported as finding valuable included advisers'

ability to listen to people, to clarify their support needs, to make judgements about whether the timing and circumstances were right for people to access support and to match them to suitable provision.

For example, a person with a physical condition said that his PSA, and the Jobcentre Plus adviser to whom he was referred subsequently, had listened more actively than other advisers he had encountered in the past. Although he did not take up the work placement and training options that were suggested, he felt that the options offered were highly appropriate and that he would have taken them up if he had not found a job shortly afterwards himself. Another person was highly satisfied with the PSA because she formed a clear action plan for him at the first meeting and was immediately able to refer him to a Jobcentre Plus adviser and to the CMP. He was impressed by the PSA's knowledge of the different options available to meet his needs and by the ability of the Jobcentre Plus adviser to organise a voluntary work placement which he felt was ideal for helping him move into a different area of work more suited to his health condition.

Conversely, where apparently inappropriate signposting and referrals were suggested, people felt that this had usually resulted from advisers not fully understanding their needs at the time. For example, a person experiencing pain in his back and legs felt that all the training options that were suggested, such as forklift truck driving, would involve him sitting for prolonged periods of time, thereby aggravating his condition. The suggestion of such options was also poorly timed because his back pain had not yet been properly managed by his doctor. He said that the possibility of joining a CMP was not raised.

Where support was accessed, the benefits derived by people reflected its purpose and function and people's specific needs and circumstances. The next few sections take each kind of service or support in turn and briefly explore the benefits experienced.

### **4.3.2 Experiences of direct support from Jobcentre Plus**

People generally experienced Jobcentre Plus staff as supportive and welcomed the involvement of an adviser in their search for work. For example, it made a difference to some people to feel able to talk about their circumstances and to feel that they would not be alone when the time came to try to return to work. One person experiencing depression said that he found his adviser very '*pastoral*' and felt that she would be able to support him to return to work when the time was right.

Jobcentre Plus staff were also described as being able to provide useful advice and information about benefits and financial incentives to support a return to work, such as permitted work rules. Not all people were aware of their eligibility for benefits and some were helped by advisers to apply for Carer's Allowance and DLA. As a result some people felt that their financial situation had improved and that they experienced less stress relating to money. Learning about permitted work from a Jobcentre Plus adviser had been an influence on one woman's decision to

return to work part-time. In some cases where people's health conditions prevented a return to their previous employment, Jobcentre Plus advisers were able to help people think about a change of work and related training

However, some people had negative experiences of their contact with Jobcentre Plus advisers. Some people were disappointed when they were told they could not obtain the help they wanted. One man receiving SSP had agreed to see a Jobcentre Plus adviser because he thought that they could help him with taxi fares to '*get about*' and, if he returned to his job, for travelling to work. Other people were disappointed when they found out they were not eligible for IB, additional benefits or financial support. People also discussed ways in which they felt that a range of provision suggested by their Jobcentre Plus adviser, such as training options, voluntary work and the CMP, did not meet their needs.

Exceptionally, one woman felt that she had not been treated with dignity by her adviser because the adviser had discussed her alcohol problem in an open plan office where other people could hear. Although this did not prevent her taking up an onward referral to an occupational therapist, she did not want to see the adviser again.

### **4.3.3 Experiences of the CMP**

People with both physical and mental health problems described improved understanding and management of their health condition following participation in the CMP. Some people described the programme as enabling them to consider a return to work or as helping them to sustain work. For example, a person who had been experiencing chronic back pain described the way in which a programme of physiotherapy, swimming and work at the gym had allowed him to live pain free and to return to his old job as an engineer.

Among people who had not yet returned to work, there was evidence that the CMP can help people with a range of health problems to move closer to work. For example, a young woman with an injury that affected her movement and depression was advised to take up a combination of physical exercises and cognitive behavioural therapy (CBT) and together these measures boosted her confidence and helped her to think more positively about work. There were people who described improved management of back pain from physiotherapy and of speech problems through speech therapy. Attending a gym and undergoing cognitive behavioural therapy were found to be helpful in easing depression, anxiety and stress. Some people who had attended group sessions described improved social confidence from being with other people and talking through their experiences of their conditions.

However, people also experienced dissatisfaction with the CMP. For example, a person experiencing depression and stress said that clinical hypnotherapy had not worked for her because it did not help her to relax. In another case, a person with chronic back pain said that, although the techniques she had been taught on a CMP course had helped reduce her pain, they involved taking her '*out of herself*'

and were not easy to apply in a work environment where she would need to concentrate. Not all people found group work beneficial. For example, a woman with arthritis and depression did not like group sessions because she said seeing people with the same condition only served to reinforce her own negative feelings about her conditions.

#### **4.3.4 Experiences of Job Brokers**

Support provided by Job Brokers that was experienced as positive included help with job searches, assistance in producing CVs, mock interviews and help to pay expenses associated with job interviews. Sometimes this support led to people gaining employment. For example, encouragement and support by a Job Broker helped a woman with a history of mental health problems to become self-employed. For her, it was important that the Job Broker had not dismissed her ideas and suggestions and had provided valuable support to produce an advertising flyer and business card. In another case, assistance provided by a Job Broker to use the computerised job search facilities at the Jobcentre Plus office, had helped a man in his late 50s find a job within days of the referral. However, some people said that, even with the support of a Job Broker, they had been unable to find a suitable job.

Job Brokers were also described as helping to ensure that work was appropriate to people's health conditions and was sustainable. For example, a woman with restricted movement felt reassured about the suitability of her new part-time retail job after talking with a Job Broker and felt more confident about sustaining her employment.

In other cases, people felt that they had not received the right support from Job Brokers to search for, or obtain, work. For example, a man in his late 50s said that, while he appreciated the work done by his Job Broker in arranging job interviews for him, he felt that these jobs were not sufficiently suited to his skills. He was critical of the Broker for not doing more to help him find a job after having made over 20 failed applications. Another man in his 50s described similar experiences and said that, as a result, he had begun to search for jobs himself. One person with a history of mental health problems noted how he had initially received help from a Job Broker to apply for jobs and voluntary placements, but was disappointed when this support had not continued over time. He felt that the lack of ongoing support had contributed to deterioration in his mental health.

#### **4.3.5 Experiences of other types of provision**

Among the follow-up sample there were people who had been referred to a range of other types of provision, though few people actually had experience of them. For example, people reported positive experiences of Work Preparation, WORKSTEP, voluntary work and help from work psychologists. One woman who had returned to work part-time following a major operation said that she felt reassured about not working full-time after talking with an occupational therapist. She felt that



without this support she might have increased her hours and that working part-time had helped her to sustain work. Some other people had benefited from attending training courses including IT courses, English language classes, basic skills training and confidence-building courses.

## 4.4 Positive impacts of the journey back to work

### 4.4.1 Returning to work

People who had returned to work since meeting with the PSA were employed in a variety of different sectors, including manual work, office administration, IT, retail and domestic or service jobs. These included full-time, permanent jobs, as well as part-time and temporary work. Most people who had returned to work had found new jobs or become self-employed, rather than return to previous employment.

Positive and negative impacts on health and wellbeing from a return to work were reported among the follow-up sample. For example, some people said that they felt more confident and less withdrawn, less socially isolated, happier and less depressed and, for one person with alcoholism, that he was drinking less. However, other people described experiencing more stress, poor sleep and feelings of panic and of feeling tired and fatigued all the time. Occasionally, people said that the physical demands of the job were aggravating their health condition.

Some people said that their finances had '*stabilised*' since returning to work or that they were somewhat better off. However, others said that they did not feel much better off financially after returning to work than when they had been receiving benefits. Perceiving no financial gain in work was largely found amongst people who returned to part-time work, though one person who returned to full-time work said that he felt worse off because he was unpaid for any time taken off due to ill health.

However, even people who said that there were limited financial benefits commonly said that they enjoyed the feeling of being valued and useful and of getting out and participating in society. For some people with depression there were gains in seeing confidence and health improve whilst in work.

Of those who were in work at the time of the research interview, all said that the contact they had with the PSA, Jobcentre Plus staff or other services had been useful and contributed positively to making progress towards work or their return to employment. Only exceptionally had people found employment without support from the PSA and Jobcentre Plus or other services.

### 4.4.2 Moving closer to work

Those who had moved closer to work included people who had taken up voluntary work, progressed onto various work-focused support, had begun undertaking job searches and job applications or who were actively considering self-employment. These people generally described positive benefits from meeting with advisers

and undertaking work-focused activities. For these people, the PSA had prompted progress towards work by acting as a catalyst; by motivating them and facilitating access to a range of work-focused support. Subsequent services, where these were accessed, helped to address people's barriers to work and, where relevant, had helped to re-focus job search activities. For example, a man with a degenerative condition felt that the combination of taking part in the CMP and doing a voluntary work placement (organised through his Jobcentre Plus adviser) had been positive for him in providing encouragement to get out of the house, in presenting occasions when he could mix with other people and feel that he was making a contribution to the work of a charity, and in providing opportunities to learn new skills. There were gains too in feeling less depressed about his illness and more confident about the prospect of returning to part-time work in the future. Another person discussed the way in which a cognitive behavioural therapy course, alongside a training course for people with mental health problems, had enabled her to manage her condition better and to gain confidence to take up a work placement.

There was a group of people who described a range of 'work-focused activities' that had been accessed independently, rather than through Jobcentre Plus, and which were also considered to have been helpful in moving closer to work. These activities included, for example, educational courses and participation in a residents' group. Whilst people said they had gained a range of benefits from taking part in these activities, they tended to be less clear about future employment aspirations than people who saw themselves as having moved closer to work. They were also less likely to be thinking about developing specific vocational skills or undertaking job search activities.

## 4.5 Barriers to progress

There were a number of people in the follow-up sample who did not appear to have moved closer to work in the period after meeting with the PSA. Some people in this group reported positive experiences of the meeting with the PSA and of subsequent support from Jobcentre Plus and other services, but also referred to a range of barriers and difficulties that prevented progress towards work.

Some of the positive experiences and impacts reported were not work-related and involved, for example, getting assistance with benefits or finding the meetings with advisers supportive and 'pastoral'. The barriers to employment described by people included health barriers, caring responsibilities, job market constraints and, exceptionally, housing barriers. Other people had initially positive experiences of provision before experiencing a change in their circumstances that prevented further progress towards work, such as taking on new caring responsibilities.

### 4.5.1 Health and caring barriers

Sometimes people used the meeting with the PSA to access work-focused support but their health condition meant that they subsequently had to cut short

or delay their participation. For example, a woman who had been referred to an occupational therapist discontinued her appointments when her health went through a '*bad patch*'. In another case, a man referred to the CMP was told by one of the practitioners that his participation would have to be postponed until after his surgery.

There were also people who agreed to meet with a PSA even though they felt that their health was not good enough or sufficiently stable to participate in work-focused activities, or to consider a return to work. One woman was awaiting the results of a medical investigation and felt that she could not think about returning to work or commit to taking up any work-focused activities until she had the results and understood more about her condition. There were also examples of people feeling insufficiently well to make progress, having only recently been 'signed-off' from work due to ill-health and of people still in the recuperative stage after major surgery. Commonly, these people said that the PSA agreed that referral to other support was not appropriate at that time and that the PSA was unable to offer anything else other than confirming eligibility and receipt of particular benefits.

Another barrier mentioned by people in the follow-up sample was having caring responsibilities for sick or disabled family members or for children. People had either felt unable to take up suggestions from Jobcentre Plus advisers, for example for training, or had had to curtail an activity such as participation in the CMP.

#### **4.5.2 Job market constraints**

There were a number of people who felt unable to return to work because of discrimination they felt they had experienced, or expected to face, in the labour market. This group included older people, people who were severely disabled or terminally ill and some people with mental health conditions. Some people had hoped that support from the PSA, Jobcentre Plus and other services would lead to employment but had then found it hard to find a suitable job. For example, a woman with terminal cancer felt capable of doing some work but was unable to find employment and was disappointed that she was not offered more support with her job search. Some older people felt that the support they were being offered by Job Brokers did not adequately address the reasons why they were being repeatedly turned down for jobs. There were also people who were sceptical from the outset about advisers or external organisations such as Job Brokers being able to help them find employment. One person who had a mental health condition said that he felt he would never be employed as long as he was honest with prospective employers about his past medical history.

## 4.6 Conclusion

As we have explained in Chapter 1, it is not a straightforward task to assess the effectiveness of a 'gateway' service whose objective is to connect people with other services that eventually might help them into work. In this chapter, therefore, we have restricted the analysis to what people actually did after their meeting with a PSA and their assessments of how it was helpful (or not) to them.

From the survey findings it appears that, at the time of the research interviews, over half of the suggestions made by PSAs were acted upon by the people they saw. It was particularly noteworthy that the sub-group of people in the sample who had originally seen the PSA for a non-work-related reason were actually more likely to have done something after their meeting than the rest of the sample.

The evidence from the follow-up sample suggests that most referrals made by PSAs produced something positive for people, whether from the immediate referral or from subsequent action by, for example, a Jobcentre Plus adviser or Disability Employment Adviser. Where people had not made progress, there is some evidence that referrals might not have been appropriate but also that other changes in people's lives, such as in their health status or their caring responsibilities could have impeded or halted their progress.



## 5 Assessing the pilot

As explained in Chapter 1, the size and nature of the Pathways Advisory Service pilot precluded any sort of experimental design for its evaluation. As was also explained, it is not a straightforward exercise to identify how an effective 'gateway' service might be measured. The original intention of carrying out a follow-up survey in which it would have been possible to measure people's moves towards work was also abandoned due to the slower than expected flow of people using the Pathways Advisory Service.

We have, therefore, based this assessment of the pilot mainly on the qualitative evidence from the main actors (patients, GPs and PSAs) about what **difference** they have perceived from taking part in the pilot. Some limited quantitative data was collected in the survey of pilot participants and is presented in Section 5.3.

### 5.1 GPs' views

Overall, the GPs taking part in the pilot were enthusiastic and positive about the service. They valued the access to types of advice that they could not provide themselves and felt that they could engage in a discussion about work with patients on a much more constructive basis than previously. The physical presence of the PSA in their surgeries for some part of every week was also important for them. They valued having a named and (over time) trusted person to whom they could refer patients with confidence. Overall, GPs liked being able to activate support for patients with the minimum of formal procedures.

#### 5.1.1 Evidence of positive impacts for some patients

While surgeries did not keep systematic data on the outcome of patients' meetings with a PSA, all of the GPs who were interviewed cited examples of people who had experienced positive changes in their lives, including taking up paid employment (or other kinds of productive activity), improvements in health and increased income. GPs who received regular feedback from PSAs firmly held the view that their patients benefited from having access to employment and other advice. These examples reinforced GPs' positive attitudes towards the PSA role.

In the research interviews GPs were asked if they had perceived any effects on the consultation rates of the patients they had referred to the PSA or on the volume of prescriptions they issued to them. Most GPs found it difficult to respond with any certainty but all could refer to individual patients who had moved into work and whom they now saw less than in the past. However, one GP suggested that this was axiomatic: *'people who work see their doctor less, and don't need lots of prescriptions. It's as simple as that'*. The consensus view was that anybody who started some form of meaningful activity, particularly those with mental health conditions, would experience improvements in their general health and wellbeing which they would expect to see reflected in a reduced number of visits to their GP.

### **5.1.2 A new option for GPs in managing patients' health**

One of the most useful aspects of the Pathways Advisory Service for GPs was the additional option it offered them in managing their patients' health. Many GPs said that before the pilot they might talk to patients about work but often in general terms only and often without much effect if a patient was reluctant to engage in such discussion. Some GPs described that now, in contrast, they were confident that there was a range of options available for patients and could, therefore, be encouraging, enthusiastic and positive in suggesting meeting with a PSA. This contrasted with previously when all they felt able to do, for example, was to suggest contacting Jobcentre Plus or a Citizens Advice Bureau without knowing much about who, or what, they were actually recommending.

Although some GPs in the study had experience or a special interest in occupational health medicine most felt that they had only limited knowledge of how work affected health and vice versa for individual patients and more generally in relation to some types of job (for example in manufacturing industries). This hampered them in what they could discuss with patients. There was a general view that the gaps in their knowledge became much less of a hindrance when there was an 'expert' on site who did have such knowledge.

One GP talked vividly about how patients and doctors could both 'get into a rut' of a patient with a chronic health condition asking routinely for sickness certificates and the GP routinely supplying them without thinking about any alternative to continuing life on benefits. Another GP talked about the frustration of being faced with patients who asserted they could not work or that work would exacerbate their condition. Previously she had little to say to challenge such views. PSAs now offered a new and different option to her and she felt she had something constructive to suggest to patients whom she called the 'permanent sick'. Some GPs reported seeing patients after they had met the PSA and getting positive feedback which had the effect of enhancing their own relationship with the patient.

Some GPs referred to increases in their own knowledge about what help was available that in turn enabled them to discuss work more authoritatively with people. For example, one GP mentioned that her understanding of how a phased

return to work could be organised and operate allowed her to raise this possibility with appropriate patients.

### 5.1.3 The value of benefits and other advice

GPs were very aware of the importance of social security benefits and employment programmes for their patients but most admitted very low levels of knowledge. Before the pilot, they had felt hampered if a patient raised the subject of benefits when they had tried to engage them in a conversation about work. If a patient responded that work 'wasn't worth it' then it was difficult to make any progress from there. Some GPs were aware, for example, of the existence, but not the detail, of tax credits and return to work payments. They could now confidently recommend seeing a PSA who had knowledge not only of benefits but also of a range of other financial measures that might help their patients.

A number of GPs commented that people's health was affected by a range of non-clinical factors, such as finances, housing and family circumstances. Hence, they would use the PSA as a way of helping people with any problems or needs that they presented in the surgery. Their experience, that the PSA could actually provide useful advice to their patients on a range of issues apart from employment, contributed to their positive views about the value of the service.

### 5.1.4 The importance of locating PSAs in surgeries

Having a PSA on the surgery premises held a number of advantages for GPs. Based on the reactions of people they had told about the PSA, they felt that their patients were more prepared and happier to see an adviser at the surgery than to visit Jobcentre Plus. For many people, they felt Jobcentre Plus was not a place they trusted or wanted to visit.

GPs also valued the ease with which they could set up meetings between patients and PSAs. Several commented that if getting access to employment advice involved, for example, having to telephone a Jobcentre Plus office, they would almost certainly not do it. They wanted to be able to recommend the services of someone they knew personally and trusted to give good advice. They did not want to recommend anything that they had doubts about as this might carry risks for their patient and for their relationship with the patient. In effect, they wanted to recommend an 'employment adviser' rather than generic 'employment advice'. In addition, ringing Jobcentre Plus would be too time-consuming to do in the course of a busy surgery.

It was also possible on occasions when the PSA was in the surgery to arrange **immediate** access to them. Some GPs in the pilot liked this opportunity and made use of it. A PSA's presence also allowed GPs to receive informal feedback about patients and to discuss with the PSA the possible options being considered.



## 5.2 Pathways Support Adviser views

The PSAs in the study were able to provide a different perspective on the service they were able to provide, particularly as they all had, or continued to have, experience of other roles within Jobcentre Plus, such as IB or other personal advisers, and Disability Employment Advisers.

### 5.2.1 Linking health and employment

Many felt an important advantage of their role was in being able to provide a link between health and employment interventions that was difficult to establish when working in other Jobcentre Plus capacities. What they were able to advise in their role as PSAs was with knowledge of people's health circumstances, often informed by discussions with the person's GP. This gave them more confidence that they were suggesting the most appropriate course of action for people at the time they saw them. Sometimes, as we have seen from Table 3.3, the advice was not to do anything immediately but to wait for health to improve or to talk to the GP again about work. This type of response kept open the possibility of seeing the patient again later at a more appropriate time.

PSAs also saw their links to Jobcentre Plus as important. They knew what could be offered, they knew the staff to whom they might be referring patients and they had access to benefit advice and better off calculations if necessary. Importantly, they could access Jobcentre Plus computer systems in order to keep track of the progress made by people. This had two advantages: First, it enabled them to feed back to GPs and secondly, it enabled them to identify where people had seemingly become 'stuck' and, therefore, them the opportunity of either discussing with the GP, or someone in Jobcentre Plus, how to make more progress.

### 5.2.2 The importance of locating PSAs in surgeries

A strong view among PSAs was that seeing people in the surgery gave them a number of advantages. Most fundamentally, it created the opportunity for talking to people who might not otherwise have made contact with Jobcentre Plus. They felt they were able to address some of the negative perceptions of Jobcentre Plus that many people seemed to have. Although not all patients who were referred kept their appointments, the PSAs thought that overall they achieved a high 'strike rate'.

PSAs were also able to build on the 'message' that a referral from a GP implicitly carried. They commented on the strong influence that they found GPs could have over their patients. They were able to encourage the patient to think that work was possible and that their GP thought so as well. Some contrasted meetings with patients and meetings with claimants in their role as Jobcentre Plus advisers. In the latter they were frequently faced with claimants who might say, for example, that *'my doctor says I can't work'* or who responded to suggestions by saying that they would *'need to check with my doctor first'*. The direct referral from a GP meant that they could circumvent such responses by reminding the patient that the GP

had already endorsed thinking constructively about work by making the referral in the first place.

### **5.2.3 Potential for helping patients not yet on IB**

Because SSP claimants only formed a small percentage of the survey sample, there is little evidence on their direct experiences of seeing a PSA. However, some PSAs thought they could potentially be very helpful to people off sick from work either on SSP or occupational sick pay. They were able to offer a range of advice on job retention, including referrals to the CMP, and had experience of liaising between employers and employees about, for example, phased returns to work or financial assistance such as the Access to Work scheme.

### **5.2.4 Characteristics required of a PSA**

There was a recognition among PSAs themselves that their role required them to act in different ways compared with, for example, an adviser in a Jobcentre Plus office. They needed to be able to work with GPs, Practice Managers, and a range of health professionals within a surgery and adopt a different role with their colleagues. They recognised that they needed to have strong skills as negotiators, motivators and communicators.

## **5.3 Pathways Support Adviser client views**

As explained in Chapter 1, any evaluation of a new service needs to address the **counterfactual** question of whether any outcomes for people who have engaged with a particular intervention would have happened anyway in the absence of the intervention. In this study we used the follow-up interviews to explore people's own perceptions of the difference made by meeting with a PSA. We were interested in exploring the research question of whether PSAs were engaging and activating people who might otherwise have continued to receive benefits on a long-term basis.

### **5.3.1 How PSAs influence people's decisions**

The survey of the pilot participants took place around three months after their meeting with a PSA which meant it was not possible to explore the longer-term effects of the pilot. However, in one question, people who attended a meeting with a Jobcentre Plus adviser after seeing a PSA were asked if they thought they would have arranged such a meeting anyway. Table 5.1 presents the responses.

**Table 5.1 Influence of PSA on Jobcentre Plus adviser visit**

<b>Whether respondent would have visited Jobcentre Plus without seeing PSA</b>	<b>%</b>
Definitely would have done anyway	22
Might have done	15
Definitively did because of PSA	63
<i>Weighted n</i>	73

Base: All respondents who had visited Jobcentre Plus.

The number of people in the sample who had attended a Jobcentre Plus meeting by the time of the research interview was relatively small but over six out of ten did say that the meeting took place only because of seeing a PSA.

In the follow-up interviews with 45 people, the same question was addressed of how influential people thought the PSA was in their subsequent progress towards work. Although qualitative sampling does not allow any generalisations to the population of Pathways Advisory Service users, it was noticeable that all of the sample who were in work at the time of the follow-up interview (nine people) said that the PSA had been influential in their route back to work.

There was also other evidence of the difference made by PSAs from the follow-up interviews. In the sample, people on benefits other than IB had not accessed the sort of support available through Pathways to Work before nor had they expected to. This was reflected, for example, in a comment from one person that PSAs did a lot more than '*typical Jobcentre things*'. These people commonly said that they would not have proactively approached Jobcentre Plus directly, either because they would not have known about the provision that might have been available or because they did not feel comfortable in the Jobcentre Plus office.

Also, many of the IB claimants in the follow-up sample, who in principle had access to Pathways to Work support either through compulsory or voluntary WFIs, said they had not been offered Pathways provision previously. It appears, therefore, that PSAs were providing access to work-focused help and support to a range of people who had not previously been aware of it and were unlikely to access it elsewhere.

In one case, for example, a person with a physical disability in receipt of DLA had been ineligible to access Pathways to Work support until the pilot. When she explained to her GP that she had been unsuccessful in looking for work, he suggested that she see the PSA. The patient was subsequently referred to a Disability Employment Adviser who organised a work placement that the person found useful in updating her skills and clarifying future work options. Another example was a person who had been in receipt of SSP at the time of meeting the PSA. He was signposted to the Disability Rights Commission by the PSA and provided with referrals to both the CMP and to a work psychologist who he believed

would help sustain his return to work. He commented that the PSA did more than Jobcentre Plus advisers he had encountered previously. A further example is of a man on IB who said he had not previously been offered work-focused support but had been referred to an IB personal adviser and the CMP by his PSA. He was later given support to access voluntary work by his Jobcentre Plus adviser and made significant progress towards work. He commented that he would not have come across this help and support if it was not for meeting with the PSA.

Even where people had been aware of information about available help and support, for example, through previous contact with a Jobcentre Plus adviser, the meeting with the PSA was useful as an opportunity to explore more fully the options available, because there was time to talk through all the possibilities in detail.

### 5.3.2 The importance of locating PSAs in surgeries

Locating PSAs in GP surgeries did appear to engage a range of people who were unlikely to have accessed support through Jobcentre Plus. Some people, particularly those with mental health conditions, said they felt more relaxed and comfortable in this setting. For example, one person said that it was useful to see the PSA in the GP surgery as she was not comfortable going '*anywhere unusual*'. People also discussed the importance of being seen in a private room, with some contrasting this positively to the expectation that they would be asked to discuss sensitive and personal issues in an open plan setting at Jobcentre Plus. Others said that either they disliked going to the Jobcentre Plus office or that they would not have made the effort.

## 5.4 Delivering a 'gateway' service

As we explained in Chapter 1, the Pathways Advisory Service was designed specifically on a 'gateway' model of delivery in which the PSA gave advice and support in a single meeting. One of the research questions we attempted to address in the study was the extent to which this model was actually adhered to and to explore the reasons for any deviations from it.

In the survey people were asked how many times they met the PSA in the GP surgery. Table 5.2 presents an analysis of the responses.

**Table 5.2 Number of meetings with PSA at GP surgery**

Number of meetings	%
One	85
Two	10
Three or four	6
<i>Weighted n</i>	212

Base: All respondents.

Table 5.2 provides strong evidence that the one-meeting gateway model was adhered to for the large majority of the survey sample. The reasons why people might have more than one meeting were not pursued in the survey but the question was explored with PSAs, GPs and people in the follow-up sample.

People in the follow-up sample typically recalled one face-to-face meeting with a PSA, whether or not they were subsequently referred on to other provision, and understood that this was the purpose of the Pathways Advisory Service. Only one person had had a second face-to-face meeting with a PSA, which he had requested in order to find out whether he was receiving the correct benefits. Another respondent said she had been contacted on the telephone by the PSA which she said was to '*check on her progress*'.

PSAs gave some more examples of where they had seen a patient on a subsequent occasion. They explained that this happened most frequently when they felt that the initial meeting had come at the wrong time for the patient when they were not yet ready to take the next step towards work. In such cases they would recommend that the patient see them again when their health had improved, perhaps after discussing work again with their GP. On other occasions some PSAs had suggested the person return to see them when some other aspect of their life which was a barrier to work (such as financial problems) had improved. In both these types of case, it is apparent that the PSA was carrying out a **deferred** gateway service rather than providing something different or additional compared with people who only had a single meeting with them.

PSAs also gave a small number of particular examples where they had seen a patient more than once to provide further encouragement or 'moral support' to them. These would not be arranged meetings but tended to happen *ad hoc* when the PSA and patient were in the surgery at the same time.

One departure from the gateway model has already been mentioned in Section 5.2.1 where the PSA might intervene with a GP or member of staff at Jobcentre Plus when a patient seemed to be making no progress. They explained that this could be an important intervention because their own reputation with GPs relied on patients making progress. They felt that GPs would lose faith in the Pathways Advisory Service (and Jobcentre Plus service more widely) if patients they had referred appeared not to be getting the support promised and needed.

Some GPs also mentioned that they might make a second referral to the PSA themselves if the initial meeting had resulted in deferring further action until a later date.

We have noted in Chapter 3 that PSAs often arranged appointments on behalf of patients with Jobcentre Plus or other organisations. It was interesting, therefore, that in the follow-up interviews some people thought they had not been given sufficient support to follow up suggestions from the PSA. In particular, some people with mental health conditions felt that their PSAs had not fully understood the extent of the emotional and practical support they needed to pursue support

options or take up referrals. For example, a young person experiencing depression said that it would have been more helpful if the PSA had introduced him directly to a named contact in a signposted organisation rather than being told to contact the organisation himself. Another person with a mental health condition and arthritis said that she was told by the PSA to contact her within a week if she wanted to take up any of the support discussed, including the CMP. When she did so to say that she would be interested in taking part in components of the CMP, she felt that it was inappropriate that she was asked to call back because her PSA was unavailable. She felt that it should be the PSA's responsibility to follow her up and not the other way around and was annoyed and disappointed that there was no further contact from her adviser when she failed to call her back. She subsequently did not take up any referrals and was still in receipt of DLA six months after seeing the PSA. In another case, a person felt that she had not received sufficient encouragement from the PSA to look for work and said that she wanted to be '*pushed harder*' in the same way she had been when she had previously received JSA.

## 5.5 Conclusion

In this chapter we have attempted to address the difficult issue of the 'effectiveness' of the Pathways Advisory Service. As we have discussed in Chapter 1, there is no obvious metric of effectiveness that automatically suggests itself as applicable to a service that is a 'gateway' to a wide range of provision, the content and quality of which are outside the control of the PSA.

Having said that, there is a consistent body of evidence from the qualitative interviews and from the survey that the Pathways Advisory Service has 'added value' for all of the key actors.

For GPs, the service has provided an additional resource for them in managing their patients' health and constructively fills gaps in their knowledge (about employment programmes and benefits in particular) that they have found to be a barrier in discussing work with their patients in the past.

PSAs have been able to engage some people in thinking about work and also to connect people with services and provision who, from the evidence it seems, would not have done so otherwise.

One conclusion that is also possible to draw about the Pathways Advisory Service from across all the sources of evidence is that its effectiveness is, in large part, derived from the innovation of locating the advisers in the GPs' surgeries. The service is, in effect, an example of a successful 'outreach' approach that brings the service close to those who can benefit from it. It minimises the efforts that GPs and patients need to make and thereby removes one of the barriers that prevents people from engaging with Jobcentre Plus.

The pilot has also reinforced the findings from other studies of welfare to work programmes that one of the key influences of effectiveness is the timing of advice and interventions. For example, the compulsory regime of WFIs for new IB claimants in Pathways to Work areas is sometimes carried out at a time when people are not yet ready, physically or mentally, to make moves towards work (Corden and Nice, 2006). The PSA, in contrast, can adapt to provide input at a time that matches people's own readiness for work.

## 6 Conclusions and policy implications

In this final chapter we present the conclusions from the research project and discuss some of the policy implications that follow. As we have mentioned elsewhere in this report it is not a straightforward exercise to evaluate the effectiveness of a service that has been designed as a 'gateway' to other help and support. In drawing conclusions from the study therefore we will begin by reflecting on the policy aims that were established for the pilot by DWP. These were to:

- provide early help and support through Pathways to Work to people on SSP to prevent the development of a health condition or disability leading to the loss of a job;
- encourage people who have little contact with Jobcentre Plus, including existing IB recipients, to access appropriate return to work services;
- deepen the relationship between health professionals and Jobcentre Plus;
- increase GPs' ability to help their patients progress towards work by providing access to interventions not available through standard NHS services.

The effects of the Pathways Advisory Service have, however, extended beyond these initial policy objectives and we summarise these also.

It is also important to remember that because of the nature of the pilot and the constraints on the research design and implementation, it is not possible to address whether the pilot was cost-effective or value for money. Such questions were outside the remit of this research study.

In the second part of the chapter we use our conclusions as the basis for discussing a number of policy implications about the design and delivery of the Pathways Advisory Service.



## 6.1 Conclusions – meeting policy aims

As a general conclusion, the findings from the research suggest that the aims behind the pilot have been largely met and that the 'gateway' model of delivery is a viable mechanism for connecting people with a range of employment and other support.

We elaborate on this overall conclusion by looking at each of the four policy aims set out above and by setting out additional findings that can inform policy thinking.

### 6.1.1 Provision of early help and support to SSP recipients

The Pathways Advisory Service is set up to provide advice and guidance to people in work as well as those out of the labour market. The pilot has also allowed people on SSP to have access to services usually restricted to Pathways to Work clients, such as the CMP.

The evidence from both the survey and the interviews with PSAs suggest that few people on SSP have made use of the pilot. Any conclusions about the effectiveness of the pilot for SSP recipients must be very tentative, therefore. The limited data on their experiences was mainly positive, demonstrating the **potential** of the PSA gateway model. Where there was some disappointment this was not about meeting the PSA, but mainly the result of people not getting subsequent support that they felt was appropriate or that would have helped them.

Interviews with GPs suggest that there is limited understanding that the scope of the Pathways Advisory Service extends beyond people out of work to those in work.

### 6.1.2 Encouraging new contact with Jobcentre Plus services

There is strong evidence from this study that people who, by their own accounts, were unlikely to make contact with Jobcentre Plus offices themselves, attended meetings with a range of staff including personal advisers, Disability Employment Advisers and CMP practitioners after meeting a PSA. Many of these also went on to participate in some form of work-related activity, and some found paid employment.

The study also provides evidence that the 'gateway' model of delivery was effective in connecting people with Jobcentre Plus (as well as other forms of help and support).

It is possible to identify a number of features of the design and practice of the pilot that contributed to its effectiveness. These include:

- referral and recommendation from a person's GP;
- quick, or immediate, access to a PSA;
- knowledge and interpersonal skills of PSAs;

- location of PSA on surgery premises;
- non-bureaucratic referral and feedback arrangements.

The study has shown that the endorsement of a person's GP can play an important first step in moving people towards work and was important in helping the PSA introduce the subject of work to the patient. It was striking that of the people in the survey sample who saw a PSA without intending to talk about work, about a third went on to have a meeting with a Jobcentre Plus personal adviser and a quarter joined a CMP by the time of the research interview (Chapter 4).

It was also noteworthy that GPs and PSAs met frequent reluctance from patients to engage with Jobcentre Plus but that that reluctance could successfully be overcome. PSAs in particular were able to provide information about services and other forms of support that people did not previously have and give reassurance about the, mostly, voluntary nature of their involvement with any work-related activity offered to them.

Locating PSAs in GP surgeries not only had the advantage of being able to offer people quick or immediate access to a PSA in familiar and non-threatening surroundings, but also facilitated contact between PSAs and GPs (and other practice staff). This frequent and regular contact allowed the development of informal referral and feedback arrangements (much valued by GPs) and was important in helping PSAs build a trusting relationship with GPs in particular but also other staff.

### **6.1.3 Deepening the relationship between health professionals and Jobcentre Plus**

Several of the findings from the study indicate that the pilot arrangements fostered a mutually useful connection between GPs and Jobcentre Plus.

GPs had gained an increased awareness and appreciation of the help available to people through Jobcentre Plus that had enabled them to talk more knowledgeably to their patients about work and to recommend seeing a PSA with confidence. For many GPs who believed that appropriate work could contribute to improvements in health, having a PSA in their surgery enabled them to have some means of putting this belief into practice and to escape the 'rut' of routinely issuing sickness certificates to people with long-term health conditions.

According to PSAs, Jobcentre Plus staff benefited from the pilot because they met people who had already had constructive discussions about work at the surgery and had been encouraged to take steps towards work by their GP. In contrast to meeting claimants who were called into the office for compulsory WFIs, Jobcentre Plus advisers were not seeing PSA referrals 'cold'.

### **6.1.4 Helping GPs to help their patients move towards work**

As presented in Chapter 5, GPs were very positive about what PSAs brought to their practices. They provided employment and financial advice and opened

access to a range of provision of which GPs previously had little or no knowledge. Importantly, GPs found they were able to have much more informed and constructive conversations with their patients about the possibility of moving towards work.

### 6.1.5 Additional conclusions

In this section we present a number of conclusions that can be drawn from the research not directly linked to the achievement of the principal policy aims.

- **Wider information and support needs beyond employment** – The evidence from the survey of pilot participants shows that people saw PSAs with a range of information and support needs that were not necessarily connected directly with moving towards work. Discussions between PSAs and patients included benefit advice and other financial help (for example, with debt), caring responsibilities, personal relationships and housing needs. Furthermore, PSAs felt they were able to offer most people some form of constructive advice or referral, whatever people initially wanted to talk about. For GPs this was very useful and an aspect of the service that they valued.
- **Promoting constructive thinking about work** – The interview data from GPs and PSAs suggest that there were two frequent barriers they were presented with by patients that they had to address. The first was people's perceptions that they could not work or would not be able to find work and the second was negative perceptions of Jobcentre Plus (including its staff and its premises).

We have shown in earlier chapters how GPs and PSAs had developed ways of addressing these barriers by adopting discursive practices that encouraged constructive thinking about work and allayed fears and concerns about dealing with Jobcentre Plus.

- **Skills and attributes of PSAs** – We have already referred, in Section 6.1.2, to the contribution made by PSAs' knowledge and interpersonal skills to the effectiveness of the Pathways Advisory Service. The related point that warrants a separate emphasis, however, is that the personal qualities of PSAs appear to be crucial to the acceptability and usefulness of the service within surgeries. Both PSAs and GPs recognised how GPs needed to have confidence that PSAs could not only provide concrete help to their patients but also that they could 'fit in' with the practice and its staff.

## 6.2 Policy implications

In this final section we discuss policy implications under the following headings:

- pilot design;
- staff recruitment and training;
- take-up and delivery.

In discussing policy implications we have borne in mind the announcement in December 2007 that the Pathways Advisory Service pilot will be extended in 2008 (mentioned in Chapter 1) and that IB is being replaced in October 2008 with a new benefit, Employment and Support Allowance, which will alter the relationship between new claimants and Jobcentre Plus.

### **6.2.1 Pilot design**

The principal components of the pilot design – including using experienced staff as PSAs, location in surgeries and the ‘gateway’ model – appear to have been largely effective in achieving the policy aims of DWP.

DWP have made the commitment to expand the number of practices in the pilot. In order to attract GPs to participate in future, therefore, it seems sensible to maintain and promote those aspects of design that were valued by GPs and PSAs in the pilot so far. There was no compelling evidence to suggest that this design needs radically amending. The pilot received very strong endorsement from the GPs in the research study.

The finding that most people who had seen a PSA were neither receiving IB nor SSP raises the policy question of whether the service should be targeted more towards these groups. However, it is likely that any form of targeting would not be welcomed by many GPs. Targeting implies that either GPs or PSAs would have to identify who is and who is not eligible for assistance. GPs in the pilot were encouraged to use the Pathways Advisory Service because there were no extra demands on their time. There was no need to learn how PSAs could help different kinds of people in order to refer the ‘right’ patients or to engage in bureaucratic referral procedures. Requiring GPs to select eligible patients would negate several of the positive aspects of the service for them.

People received help regardless of the benefit they were on and it is likely that positive experiences might encourage them to seek help again if they should claim SSP or IB in the future. Also, some people were helped to claim a more appropriate benefit and thus, receive more appropriate help (for example, by moving onto IB and gaining access to the full Pathways to Work provision). Targeting might remove the potential to help such people.

### **6.2.2 Staff recruitment and training**

The findings from the study clearly indicate the importance of recruiting staff to the role of PSA who have a range of advanced knowledge and skills. It seems particularly important for PSAs to have strong interpersonal skills that can be used in their dealings with a wide range of patients, with GPs and with practice staff.

As some GPs commented on the need for PSAs to have some basic knowledge of common health conditions, consideration could be given to whether training for PSAs should include any form of health component.

There are no specific policy implications from the finding that a few people in the study expressed some form of dissatisfaction with their experience of meeting a PSA or with referrals to Jobcentre Plus and others, apart from reinforcing the importance of tailoring help and support to individual needs and aspirations.

### 6.2.3 Take-up and delivery

The findings suggest that there are potentially more patients who might benefit from seeing a PSA than have done so already. There is a range of responses that could be made:

- increase GPs' knowledge and understanding of **who** can benefit from seeing a PSA, particularly those in work and receiving SSP;
- increase knowledge and understanding of the scope of the Pathways Advisory Service among other practice staff, particularly clinical staff;
- use multiple methods of publicising the Pathways Advisory Service to encourage self-referral, and repeat publicity at regular intervals.

Most GPs have adopted individual discursive practices that they use in talking to their patients about work and about the PSA. Some GPs have developed ways that they find work best for them. There is scope, therefore, for disseminating this kind of 'effective practice' among other GPs in order to increase the 'take-up' of the Pathways Advisory Service among patients.

PSAs acknowledge the need to keep in contact regularly with GPs in order to maintain their awareness of, and support for, the service. Effective practice here has included creating opportunities for informal contact, discussing individual patients when appropriate and perhaps most importantly, giving GPs feedback on the progress of the patients they refer. It is not clear whether existing data protection legislation precludes PSAs from using surgery computer networks or sharing information. Some clarification on these issues would be welcomed by GPs and PSAs.

It is apparent from this study that many people are reluctant or resistant to engaging with Jobcentre Plus directly. PSAs address this barrier in their conversations with patients but consideration might also be given to other proactive ideas (some of which were used exceptionally by PSAs in the pilot), such as arranging for Jobcentre Plus staff to see people in the GP surgery if required or accompanying them to Jobcentre Plus offices in order to introduce staff personally.

PSAs found the lack of management targets (for example on the number or lengths of interviews with patients or on the number of referrals or job entries) allowed a large degree of flexibility in dealing with individual people that was constructive. It is unclear whether the introduction of targets would have practical value in managing workloads given the unpredictable flow of referrals from GPs and others.

### 6.3 Final comments – the wider policy context

In October 2008 IB will be replaced by Employment and Support Allowance. The reformed eligibility conditions and new **work capability assessment** will draw more new claimants into a regime of compulsory WFIs. The question, therefore, arises of whether a Pathways Advisory Service would be necessary or would fit with the new benefit arrangements.

From the evidence of this study, it appears that people who will fall outside the remit of Employment and Support Allowance could still benefit from a Pathways Advisory Service, particularly those in long term receipt of incapacity and other benefits and people in work at risk of becoming future IB claimants. Furthermore, the value of the Pathways Advisory Service has been seen to extend beyond the target populations of IB and SSP recipients.

There also appears to be strong evidence that the Pathways Advisory Service has fulfilled a need for information and support for people not in touch with Jobcentre Plus, some of whom would have been very unlikely to have made contact themselves. Whether a Pathways Advisory Service is the most effective or efficient means of meeting those needs cannot be answered at this stage, but as we have said in Section 6.1, the research can conclude that the aspirations for the pilot have been largely met and that the 'gateway' model of delivery is a practicable mechanism for connecting people with a range of employment and other support.



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