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Experiences from the frontline: an exploration of Personal Advisers' practice with claimants who have health-related needs within UK welfare-to-work provision

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Abstract

Recent UK welfare reforms have been less successful than expected by the Government in supporting unemployed people with long-term illness into work. Frontline workers remain a core element of the new welfare-to-work machinery, but operate within a changed organisational and policy landscape. These changes raise important questions regarding whether and how claimants' health-related barriers to work are considered. This paper examines the UK welfare-to-work frontline worker's role with claimants who have long-term illness. Fieldwork observations in three not for profit employment support services, and semi-structured interviews with 29 participants

(claimants, frontline workers, healthcare professionals and managers) were conducted between 2011 and 2012. Participant observation of the wider welfare-to-work arena was initiated in 2009 and continued until 2013. A qualitative methodology drawing on ethnographic principles was adopted. Thematic analysis of the data was carried out. The findings show that the frontline worker plays a key role in assessing and addressing claimants' health-related barriers to work. Two important health-related role dimensions were identified: a health promoter role which involved giving health promotional advice to claimants about their general health; and a health monitor role which involved observing and questioning claimants about their general health. Frontline workers' practice approaches were shaped by organisational and individual factors. Integration between the National Health Service (NHS) and employment support services was limited, and the findings suggested improvements were required to ensure an adequate response to claimants' health-related needs to support their journey into work.

Keywords: frontline advisers, long-term illness, health-related support, return to work, welfare-to-work, claimants

What is known about this topic

- Claimants' health-related issues are often a barrier to work.
- Health-related support can be beneficial in supporting claimants with long-term illness into work.

- Personal Advisers are instrumental in supporting claimants into work.

What this paper adds

- Personal Advisers are shown to play a key role in assessing and addressing claimants' health-related barriers to work.
- Findings illustrate there is a weakness in the relationship between welfare-to-work and NHS provision at the frontline.
- We provide insights into the benefits of supporting integration between work and health services at the frontline.

Introduction

Addressing the rising numbers of benefit claimants and the associated costs of supporting working age people with long-term conditions and disabilities into work is a concern for governments across many Organisation for Economic Co-operation and Development (OECD) countries (OECD 2010). Despite enduring challenges to finding effective ways to support this group of people (Department for Work & Pensions (DWP) & Department of Health (DoH) 2016a, Dudley, McEnhill & Steadman 2016), in line with many OECD countries, the UK Government has retained a prominent policy focus on 'activating' claimants who have long-term illness (who number around 2.4 million (DWP & DoH [2016b]) into work (van Berkel 2014).

In the UK, eligibility for Employment Support Allowance (ESA), a working age health-related benefit, is determined by a Work Capability Assessment (WCA). Since it was introduced in 2008, the WCA has been criticised by a wide range of stakeholders particularly in relation to its accuracy in assessing a claimant's capacity to work (Baumberg et al. 2015). Consequently, many claimants who have a long-term illness have been assessed as 'fit for work' and awarded Job Seekers' Allowance (JSA) (Baumberg et al. 2015).

Both JSA and ESA (the Work Related Activity Group element) require claimants' engagement with the Government's employment support provision (DWP 2017a) with any failures resulting in potential benefit sanctions (Kennedy, Murphy & Wilson 2016). When claimants have attended these types of employment support services they have often engaged with a frontline worker - commonly referred to as a 'Personal Adviser', the term adopted for this paper- and discussed their barriers to work (Toerien, Sainsbury and Drew 2013).

Frontline Worker Roles

These frontline roles, which have numerous titles (McNeil 2009), are considered to be instrumental in supporting people into work across many different welfare states (Daguerre & Etherington 2009). However, there is international variation in relation to the: profile of Personal Advisers; recruitment process; required qualifications; training; and professional codes of conduct (Crawford & Parry 2010,

Considine *et al.* 2015). These variations raise questions about whether and how Personal Advisers respond to claimants' ill-health.

Earlier work has provided some insights into how UK Personal Advisers and claimants address health-related issues (Hudson *et al.* 2009, Newton *et al.* 2012). In addition, the Personal Adviser role has been found to have multiple dimensions (Barnes *et al.* 2010, Hudson *et al.* 2010). However, these studies have not particularly focused on health-related dimensions. This paper begins to address this gap.

The theoretical framework for the current study was drawn from Lipsky's (1980) theory of street-level bureaucracy which was developed through his observations of frontline workers' behaviour across statutory sectors, including welfare in the United States. His observations revealed that frontline workers' practice often involved working with large numbers of clients in a short timeframe with high levels of discretion. These factors led to practice dilemmas, especially when an organisation's resource constraints conflicted with the workers' ability to respond to client needs (Lipsky 1980). Current research has also shown that Personal Advisers have an ability to exercise agency (Wright 2012), discretion (Grant 2013) and are likely to experience practice constraints (Fuertes & Lindsay 2016). Therefore, there is a set of contextual factors in which the Personal Adviser is required to operate and construct their role, and it is important to understand how they manage these while working with claimants who have health-related needs.

UK Employment Support Provision

In the UK, employment support provision is governed by the DWP and delivered by their agency JCP as well as contracted provider organisations who deliver the Work Programme and Work Choice.

The Work Programme is a single payment-by-results programme that was launched in 2011. It is for nine claimant groups which include those in receipt of ESA; a higher payment is offered for supporting this group into work. The programme was initially delivered by 18 prime provider organisations and their supply chains, which include the private, public and voluntary sectors (DWP 2011).

Having a greater understanding of the Personal Adviser's role within the UK Government's employment support provision is important because an underlying policy assumption is that these external organisations will be innovative and personalise support for all claimants including those who have long term conditions. Therefore, there are likely to be a range of frontline worker roles operating across provider organisations which have yet to be understood.

The Work Programme policy assumes that improvements in the integration between health and welfare-to-work services will be fostered (DWP 2011). This approach differs from the previous 'Pathways to Work' policy which focused on a prescribed frontline Personal Adviser and a voluntary health-related intervention element (for example, see Lindsay & Dutton 2013). Previous research into this

programme has shown the value of addressing claimants' health-related barriers to work (Kellett *et al.* 2011).

Work Choice is a smaller provision that was initiated in 2010. It delivers a range of voluntary specialist employment services to meet individual needs of claimants who, because of the nature of their disability, require more specialist support than can be provided by JCP (DWP 2017b). A new DWP contracted 'Work and Health Programme' was launched in 2017 and replaces the Work Programme and Work Choice (Powell 2018).

The research question for this study was: What role does the Personal Adviser have in supporting the health of claimants with long-term illness? This paper centres on the micro level interactions between Personal Advisers and claimants and primarily reports on the experiences and practices of the staff within the participating organisations. It aims to find out: i) what strategies Personal Advisers adopted within their practice involving claimants with health-related needs; ii) what factors helped or hindered their practice and; iii) what types of health-related support was made available to claimants.

Methods

A qualitative methodology drawing on ethnographic principles was adopted. Three methods were selected. Fieldwork observations in organisations that delivered the Work Programme and Work Choice and semi-structured interviews with Personal Advisers, claimants,

healthcare professionals and managers were conducted 2011 to 2012, and participant observation of the wider welfare-to-work arena was initiated in 2009 and continued until 2013.

Recruitment and data collection

A range of strategies was employed to recruit participants including: meeting with Personal Advisers and claimants to provide information about the study and invitation letters being sent out to claimants by one organisation on behalf of the researcher. Participant observation of the welfare-to-work arena involved both purposive (identifying key informants) and opportunistic sampling strategies. All willing Personal Advisers were recruited and a purposive sample of claimants was sought. Where opportunities became available and/or new issues emerged, other stakeholders were also selected to take part. Relevant organisational and claimant related documents that were made accessible for reviewing were also collected as shown in table 1.

Ethics and consent

Written information was provided to the participants prior to gaining their written informed consent for the interviews and observations. To ensure compliance with the UK's Data Protection Act (1998), participants' consent was gained prior to accessing documents that contained their personal data. Ethical approval was gained from Sheffield Hallam University's Research Ethics Committee following consultation with the DWP.

Topic guides facilitated the semi-structured interviews incorporating ethnographic questions (Spradley 1979). Table 2 provides further details about how and where the interviews were conducted. All but one of the interviews were recorded. The initial observations of Personal Advisers' practice followed a structured format as advocated by Fetterman (2010) over time. Observation forms focused on roles Personal Advisers played and included eight role dimensions that were derived from a synthesis of earlier UK research findings (See Ceolta-Smith 2014) as shown in table 3.

Analysis

The interview recordings were transcribed verbatim and anonymized before being entered into NVivo (2011). Handwritten and typed observation notes and other collected documents (shown in table 1) were also anonymized for analysis. The data were analysed following Miles and Huberman's (1994) data reduction, data display and conclusion/verification drawing stages. Two analysis techniques were used: i) Spradley's (1979) ethnographic domain analysis techniques helped to support familiarisation of the data and gain initial insights; ii) thematic analysis: inductive and deductive (Fereday & Muir-Cochrane 2006, Braun & Clarke 2006). A priori codes were derived from an earlier review that identified eight role dimensions (see table 3). Before the conclusions were drawn, the themes were reviewed and refined through discussion with two researchers who formed a supervisory team. The extended period of participant observation

also allowed further verification of the conclusions drawn from the observations and interviews.

Findings

Four organisations agreed to take part in the study: three were Work Programme providers and one was a Work Choice provider. One organisation was a private subcontractor for a prime provider and three were non-profit sector. Although data were gathered from a private subcontractor, this organisation withdrew from the study at a later stage. This data is not included in the findings presented below. 32 days of observations and 29 in-depth interviews were conducted. Tables 2 and 4 show the participant characteristics. Three main themes: Personal Advisers' health-related role dimensions; Personal Advisers' key health-related practice tasks; and factors shaping Personal Advisers' practice approaches are presented below with illustrated quotes.

Personal Advisers' health-related role dimensions

The eight Personal Adviser role dimensions that were derived from the synthesis of earlier research findings as outlined in table 3 were confirmed during the new practice-level data collection. Two new role dimensions -

health promoter and health monitor - were identified from the fieldwork observations.

Health Promoter

Personal Advisers mentioned that by focusing on what claimants could do and highlighting the benefits of work, they would try to help claimants overcome their health-related barriers to working. This type of intervention could be characterised as part of a 'health promoter' role dimension which involved giving health promotional advice to claimants. This included: "taking exercise", the importance of having a good sleep and healthy diets. There were a few occasions where Personal Advisers appeared to exceed their role boundary. For example two Personal Advisers were observed suggesting claimants try certain medications to manage their health condition better.

Health Monitor

A 'health monitor' role dimension also emerged during fieldwork observations and was suggested in the material generated in some of the interviews with Personal Advisers. This included observation of claimants' health-related behaviour during one-to-ones, for example if a claimant appeared tired, or not well-groomed. Being concerned about claimants' health and any risk of self-harm was also evident. One Personal Adviser described this aspect of his role as being on "suicide watch".

Sometimes Personal Advisers were concerned about claimants who attended appointments while they were unwell:

... [the claimant] came in and she looked awful, and she was shaking, and I said, 'Are you alright?' And she said, well, she had a seizure the day before, so I was saying, 'Well, are you sure you should be here?' (P11).

Personal Advisers' key health-related practice tasks

The practice-level data confirmed that Personal Advisers' practice involved a broad range of tasks that could be carried out at different stages of a programme's delivery. To help organise the presentation of the data, an exploration was conducted of Personal Advisers' practice in relation to claimants' health during their start on a programme, and any pre work or post work support that was offered. The related activities that Personal Advisers performed - as revealed by both direct observations and interview reports - are outlined in table 5. Assessing and addressing claimants' health-related barriers to employment were two key health-related practice tasks that Personal Advisers performed.

Assessment of claimants' health-related barriers to employment

There was a diversity of practice within and between the three organisations' formalised assessment procedures. A key factor that led to this variability was the lack of consistency in the quality and sources of information about claimants' health conditions that were made available to Personal Advisers. Although helpful details about a claimant's health condition were sometimes made available prior to a

formal assessment, it was not uncommon for Personal Advisers to remark on the limited utility of documentation that they received from external sources:

... and basically on the action plan it was 'customer was really bad with mental health, stress and everything', and when I spoke to the customer they were like I didn't, I didn't see it was that bad ... (P1).

Therefore, Personal Advisers often relied on their own skills and ability to encourage claimants to disclose any health-related barriers, and to pick up on any observable behaviour that may indicate a health-related problem: "I see a lot of people that look poorly."

Fieldwork observations showed that there were also different ways in which Personal Advisers enquired about claimants' health and responded to their answers. Some Personal Advisers probed for further details as this observation quote from a first appointment between a Personal Adviser and new client illustrates: Personal Adviser: "Any effect with medication? Drowsy?" In contrast some Personal Advisers were observed not to probe. However, it was not possible to confirm whether these Personal Advisers may have been waiting for a claimant to talk about any health problems at a later stage. However, most of the Personal Advisers highlighted the importance of getting to know claimants:

...step one is just to show an interest, step two is to win his confidence, step three is for him to talk to me, not for me to be asking and quizzing him, ... and after about six or seven times of meeting we started to talk about his diabetes... (P5).

Given the variations in the formalised process for establishing claimants' health conditions, the extent to which information was exchanged was also found to vary from claimant to claimant depending on their own eagerness to share:

We don't talk much about it, unless I have to volunteer something about my health. (C28).

Consequently, health-related issues could remain outside of the Personal Adviser and claimant interaction, despite their potential relevance to securing employment.

An assessor role was adopted at different stages of a claimant's programme participation. Making sense of claimants' health-related information, and identifying factors that could affect their employability were key assessment tasks. A challenge associated with assessing this was that some Personal Advisers felt uncertain about the accuracy of a claimant's own health-related account:

One particular young lady I see, who strikes me as being quite fit, ... I think she may have a degree of curvature to her spine, but nothing severe enough to, to sort of make her bedridden for days like she claims... (P9).

In order to learn more about an individual's health condition Personal Advisers employed a range of strategies which included group work observation and consulting with healthcare professionals who were involved with a claimant. However, these strategies did not always appear to be helpful in terms of increasing a Personal Adviser's level of confidence and certainty:

We won't get any feedback from a general practitioner (GP) (P14).

I had a phone call, was it last week, from a physiotherapist ... and that's the first time anybody's ever contacted me. (M2).

Other factors that Personal Advisers found problematic in their assessments included suspecting that a claimant might have an undiagnosed health condition, or reported to have a health condition through self-diagnosis:

...you have to rely solely on what they tell you and your judgement...

(P9)

In contrast some Personal Advisers talked about the importance of shifting from a health focus (once claimants had talked openly about their health condition), to a work focus and supporting claimants with work related activities such as completing job applications. Personal Advisers' adoption of different approaches at different times illustrates (i) the extent to which a Personal Adviser's personal judgement, skills and experience might influence their practice and (ii) the level of discretion and autonomy they have in deciding how much attention they give to claimants' health issues.

Addressing claimants' health-related barriers to employment

A wide range of health-related employment barriers were expressed by claimants. Examples included: fear of travelling on local transport

(e.g. due to experiencing panic attacks) and being unable to engage in job search activities due to depression.

Two ways in which Personal Advisers might approach addressing claimants' health-related barriers were identified: (i) recommending professional healthcare led support either in-house or externally and (ii) personally providing health-related support interventions.

Recommending professional healthcare led support either in-house or externally

Personal Advisers' use of healthcare professional led support varied. Signposting and encouraging claimants to see their GP was the most common strategy that was employed. In one organisation where condition management programmes (CMP) or in-house healthcare professionals were available, some Personal Advisers valued this resource:

...if we think that somebody's mental or physical health impairment is a barrier we would refer them on and let our practitioners deal with it. (P9).

One CMP practitioner in another organisation felt that some Personal Advisers did not discern which claimants might benefit from CMP as some made regular referrals while others made none. This data highlighted how Personal Advisers might be challenged when they had the responsibility to adopt a gatekeeper role (see table 3) and decide whether to offer health-related support.

Personal Advisers often signposted claimants to health-related support provision which was available from the third sector, for example, Mind. Personal Advisers' choice of external organisations typically involved those that they had previous experience of, or were identified through internet searches. However, adopting the role of the navigator (see table 3) to search for services (including NHS-led) could be challenging. Some Personal Advisers struggled to access health-related support and this became an obstacle to helping claimants progress towards work:

...it's quite a difficult one, and that's the one where we're all stuck at, we all don't know what to do with these customers, they're kind of sat in a pot. (P1).

In the absence of identifying suitable health-related provision, one Personal Adviser was unable to offer anything to her claimants other than more time to talk. This was experienced positively by some claimants:

... least [she] has got the decency to sit and have a chat, have a cuppa, you know, and how'd you feel today ... they do show concern... (C19).

However, as shown below, having sufficient time was not always possible.

Personally providing health-related support interventions

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

...he had the condition I've got, arthritis, and you know, sciatica going on, but it's stopped him from completely working for years, and he spent years and years on sickness benefit ... and slowly, you know, obviously talking about my experiences as well with him, I'm getting him to see that possibly he could do something else. (P9).

Factors that shaped Personal Advisers' practice

Preparedness to address claimants' health-related needs

Personal Advisers had varied levels of knowledge about the health conditions that claimants experienced and talked about a range of strategies that they employed to gain a better understanding. This included: drawing on the illness experiences of claimants they had worked with, or relatives and friends, or their own experiences. Internet searching was frequently mentioned as a valuable resource for learning about health conditions:

...One of my customers, they've got a disease that is attacking the bones, I've never heard of it before, really long name, couldn't even tell you what it was, but it's basically it eats your joints away, ... Googled it and found all the information on it... (P1).

Overall, there appeared to be little consistency in the training that was provided across organisations. Most Personal Advisers spoke positively about any health-related training their organisation had provided and the potential for further opportunities. Some Personal Advisers wanted more understanding about mental health:

I think maybe the different types of mental health, how to deal maybe with people with schizophrenia, bipolar, because bipolar is totally different to depression ... (P12).

One Personal Adviser was supported by her manager to complete a counselling course, and others were involved in some form of counselling training.

A key facilitator that supported Personal Advisers' practice was having time to get to know a claimant. Time enabled Personal Advisers to feel more comfortable to broach sensitive health-related issues with claimants. However, there were factors which impinged on the time that Personal Advisers could spend with a claimant, for example, structural issues such as large caseloads; "*I had 100 plus*". It was also common for claimants to miss or arrive late for an appointment, and this had a knock on effect on Personal Advisers' daily work demands:

...if the customer's 10 minutes late then you're, 'Right, what you applied for?' (Take a photocopy of it), 'Right, here's your next appointment, we'll see you in a bit' (P3).

Therefore, Personal Advisers needed to be able to juggle their practice and contractual administrative demands.

All of the Personal Advisers in this study had to achieve job outcome targets either individually or as a team. Fieldwork observations revealed a sharp contrast between the way in which job targets and the pressure to "flog cleaning jobs" to claimants were discussed in one organisation's team meetings in relation to how these were later presented to claimants. However, in this case, any pressures arising from these performance targets were not overtly displayed by the Personal Advisers in their practice. However, one Personal Adviser in this setting said that on occasions targets influenced the way job vacancies were considered with a claimant:

...if you've got a customer who's thinking, Do I really want to work at McDonald's or not?, and you say, 'Look, it's more a step on the ladder for you', and it does help them, because obviously getting, getting work does help your confidence etcetera, ... you're thinking, Well if that person does start ... I've hit my target this month. (P15).

Personal Advisers needed to be both creative, and resourceful in their practice. Observations revealed examples where Personal Advisers demonstrated skills in being able to ask claimants important and

relevant questions relating to their health and work-related issues. Seeking solutions to claimants' health-related barriers was also evident, but not consistently observed.

Many Personal Advisers had experienced emotionally challenging events in their practice, and some worried that programme processes or interventions might cause harm to a claimant who may already be vulnerable:

...a customer the other day, and he didn't want to come to his first appointment with us, and it's like, 'Well you've got to, mate. I've got to get the paperwork done and get you signed on to programme', and you know, I thought, well he was very upset and he was very irate, and I thought he might do something to, might hurt himself, and I'm just trying to do my job...(P14).

Personal Advisers' practice also posed risks to their own health:

...there was a member of staff who was struggling ... she was a sufferer many years ago of mental health, and she understood some of the customer's needs and concerns, and I think it was just a bit overwhelming. (M16).

There were examples where provider organisations employed coping mechanisms to help Personal Advisers manage these types of situations. For example, one organisation was observed to follow a safeguarding protocol if claimants were felt to be at risk. Team meetings and supervision were also important:

I always go around the table and ask the staff individually how they feel they've done ... any concerns, any successes... (M2).

Discussion

This study drew on past work that had revealed the complexity and multi-dimensional nature of the Personal Adviser role and sought to extend this analysis to examine in detail how health-related issues were tackled. Personal Advisers were found to play a key role in assessing and addressing claimants' health-related barriers to work. Their engagement in some elements of the identified health-related role dimensions was akin to those of healthcare professionals. However, there were limitations in some Personal Advisers' understanding of claimants' health conditions and related barriers to work, and ways in which to offer support.

Overall, this current study found that Personal Advisers were likely to have varied levels of training and competencies in being prepared and equipped to support claimants with health conditions. This finding is of importance, because a lack of knowledge in health was associated with Personal Advisers' inability to help some claimants make progress into work. There were also risks in overlooking claimants' health-related issues if Personal Advisers lacked confidence, skill or knowledge of appropriate resources. This is of concern, and findings from the Work Programme evaluation suggest this is a widespread problem, since 70% of those who had challenges in finding work because of their health conditions were not offered health-related

support (Meager, Newton & Sainsbury 2014). Most Personal Advisers in this current study were aware of their knowledge and skills gaps and desired more knowledge of mental health conditions and health provision. This finding concurred with other empirical evidence (McNeil, 2009).

Different Personal Adviser roles were proposed to operate within the Work Programme delivery models and five of these were outlined to be specialist and health trained (Ceolta-Smith, Salway & Tod 2015). Specialist Personal Adviser health roles were not identified during our fieldwork, but these have been established by some Work Programme providers over time (DWP 2014). This finding reflects a response to the increase in ESA referrals to the Work Programme (Bivard 2016) and recognition of the need for a health-related frontline worker role.

Implications for future practice or research

Lessons could be learnt from the four Work Programme providers who proposed healthcare professional roles within their delivery models, three of which were documented to support Personal Advisers (Ceolta-Smith, Salway & Tod 2015). This way of working was found to be of value in the previous Pathway to Work programme, despite some tensions between Personal Advisers' and healthcare professionals' differing approaches to addressing work and health (Pittam, Secker & Ford 2010). One Work Programme case example describes this type of joint working as facilitating positive delivery and

performance (DWP 2014). Further research is needed to explore whether and how other Work Programme providers have utilised healthcare professionals within their programmes.

This current study found that there were weaknesses in the relationship between health and welfare-to-work provision despite the Government's expectations that integration would be developed (DWP 2011). There is a need to find an appropriate approach to not only sharing health information, but developing integration at a local level (Dudley, McEnhill & Steadman 2016). Integration has been identified as a successful feature of one of DWP's pilot programmes, 'Working Well', which has adopted a Key Worker model for providing tailored support for ESA claimants who have left the Work Programme (Dickinson 2015).

This current research showed that Personal Advisers needed to navigate local health-related services. Such navigation is important since many Work Programme participants with health-related barriers to work have not been offered health support (Meager, Newton & Sainsbury 2014). Therefore, a commitment from welfare-to-work providers to permit their frontline workers time to get to know NHS staff and the landscape is required. However, this current study has demonstrated organisational level constraints that need to be addressed, including large caseloads which undermined personalisation of support. Importantly, lower caseloads have been

key to tailoring support within the 'Working Well' programme (Dickinson 2015).

Work Programme research has shown that frontline workers have centred on '*work-first interventions*' (Fuertes & Lindsay (2016) p537). Similar findings were found in the Work Programme evaluation, however some improvements in frontline workers adopting a personalised approach were evident over time (DWP 2014). These findings concur with Conisdine *et al.*'s (2015) study that revealed how employment providers' governance of their frontline staff shaped practice approaches and networking activities. Thus it is crucial for policy makers to identify creative solutions to support work-health collaboration at the frontline.

Moreover, effective collaboration may mitigate any tensions associated with the expected resource restrictions in the new UK 'Work and Health Programme' (Oakley 2016). Such restrictions are likely to hinder the support that can be made available, and may risk a frontline worker being unable to help their clients to progress into work or overstretching their professional boundary.

This study has identified new issues relating to Personal Advisers' role boundaries, scope of practice and accountability related to claimants' health. Personally addressing certain health-related barriers was viewed by most Personal Advisers as a legitimate task to perform.

However, understanding the impact of a claimants' health condition and identifying suitable forms of work can be a challenging task, and healthcare professionals have struggled to achieve this (Cohen *et al.* 2010). Importantly, there are many differences between the role of the Personal Adviser and a healthcare professional. Healthcare professionals are required to pass an accredited course of training and to follow their regulatory body's ethical code of conduct and standards of practice. (For example, see The Health & Care Professions Council 2016). In contrast, the Personal Adviser role has only begun to achieve some of these requirements with a code of conduct for UK Personal Advisers who decide to become members of the Institute of Employability Professionals (2011).

Strengths and limitations

This study has provided valuable insights into the ways in which some Personal Advisers work with claimants who have long-term illness. The themes were identified from a range of data sources which were used to corroborate the findings (Bowen 2009). These themes are likely to have important implications for new employment support programmes and future practice.

This research confirms elements of Lipsky's (1980) theory and has shown that welfare-to-work frontline workers have high levels of discretionary judgement when interacting with claimants who have health-related needs.

However, there may be limitations to the transferability of the findings to other settings where organisational culture, structures and processes might vary. This study's sample is limited because it involved Work Programme subcontractor organisations, rather than a prime's delivery (i.e. lead contractor). In addition, the number of organisations and participants involved was small and therefore further research involving different types of employment support provision and frontline roles is needed to assess whether the findings presented here are more widely applicable.

Conclusion

Supporting individuals with health conditions into work remains a policy priority and a persistent challenge for the UK and other OECD countries. This study has confirmed the multidimensional and complex nature of the UK Personal Adviser role and described it in relation to this challenge. Personal Advisers were found to have varied levels of training, competencies and organisational support to respond adequately to claimants with health conditions. There is a need to find effective approaches to supporting Personal Advisers' practice with claimants who have long-term illness and work focused health-related needs.

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Conflict of interest

The authors declare no potential conflicts of interests with respect to the research

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Table 1 Summary details of the participating organisations and volume and range of data generated

	Site One (non-profit sector end to end delivery with specialist role)	Site Two (non-profit sector end to end with specialist intervention)	Site Three (non-profit sector end to end with specialist role)
Description	Office type: formal with 1:1 rooms, semi-open plan area and group rooms.	Office type semi- informal, private 1:1 rooms and group room.	Office type: formal with open plan area, group rooms sometimes used for 1:1s.
Staff mix	Managers, Personal Advisers, administrator and volunteers.	Managers, Personal Advisers, healthcare professionals, administrator and volunteers.	Managers, Personal Advisers and administrator.
Staff who left their employer or changed position during the study	Manager, Personal Advisers and administrator.	Manager and administrator.	Manager and Personal Advisers.
Events observed	1:1 face-to-face interviews and telephone interactions with claimants. Group work: job clubs, preparing for job applications and motivational workshops. Team/supervision meetings. Peer discussions: claimants and Personal Advisers. Reception area. Claimant waiting area. Interactions involving claimants' parents.	1:1 face-to-face interviews and telephone interactions with claimants. Group work: welcome inductions. Condition Management Programme session. Peer discussions: claimants and Personal Advisers. Reception area. Claimant waiting area. Interactions involving claimants' carers.	1:1 face-to-face interviews and telephone interactions with claimants. Group work: job clubs. Peer discussions: claimants and Personal Advisers. Reception area. Claimant waiting area. Interactions involving claimants' carers /partners.
Artefacts /data sources available for reviewing *	Posters, notice boards, leaflets, claimants' feedback forms, action plans, claimants' appointment letters, group resources, intranet policies and procedure manuals, organisational statistical information, power point slides and videos for group work, flip charts and claimants' thank you cards.	Posters, leaflets and power point slides for group work.	Notice boards, leaflets, and group work manuals.
Participants observed	In receipt of ESA or JSA	In receipt of ESA or JSA	In receipt of ESA or JSA
<p>NOTE: Observation sessions included a whole /half day, individual interview and in-house group activities. The total number of days observed was 32. * Consent to access any claimant records was obtained from the participants. Abbreviations: - Employment Support Allowance (ESA) -There are two groups associated with this benefit-i) the support group who are not deemed fit for work within 12 months and are not subjected to conditionality and ii) the work related activity group who are required to participate in work related activities to prepare for work within 12 months (DWP 2017a). Jobseeker's Allowance (JSA) -This benefit is for people of</p>			

working age who are expected to seek work (DWP 2017c). Universal Credit has since been introduced in some parts of the UK and this single benefit will replace ESA and JSA.

Table 2 Summarised participant characteristics and interview details from the 29 semi-structured interviews

Semi-structured interviews	Number	Sex	Age	Benefit type and duration	Interview length range of time	Interview method	Interview location
Personal Advisers	11 WC 4 WP 7	4 male 7 female	Range 26 to 53 Mean age 36.6*		30-60 minutes	10 face-to-face 1 telephone	Private rooms at the provider organisation's offices
Claimants	11 WC 4 WP 7	9 male 2 female	Range 26 to 53 Mean age 44.6*	10 JSA 1 ESA Duration- 6 months to 13 plus years	45-60 minutes	10 face-to-face 1 telephone	Private rooms at an agreed and accessible community location or in the provider organisation's offices Own home
Work Programme healthcare professionals	3	1 male 2 female			60-90 minutes	3 face-to-face	Private rooms at an agreed and accessible community location or in the provider organisation's offices
Programme managers	4 WC 2 WP 2	2 male 2 female			30-60 minutes	4 face-to-face	Private rooms at the provider organisation's offices
Total	n=29						

NOTE: * Ten Personal Advisers and ten claimants provided their age. All of the healthcare professionals were senior practitioners (with more than five years' experience) and each had a different professional status. They had all worked in the previous policy initiative the Pathways to Work Condition Management Programme. This programme was a voluntary provision which offered claimants a range of self-management interventions for their health and work (See Lindsay and Dutton [2013]). The Personal Advisers' work experience ranged from one to 19 years. Many of the Personal Advisers had worked in either recruitment, Jobcentre Plus, or for another provider organisation delivering employment support. One of the Personal Advisers had a dual role as manager. The managers' experience varied, for example, one had considerable experience covering more than fifteen years in the welfare-to-work sector and another had related experience in the same sector. The above participants have been given an identifier number 1-18 in the data quotes provided. Many of the claimants had recently claimed Employment Support Allowance or Incapacity Benefit and some had experience of the medical assessment for benefit entitlement which is called the Work Capability Assessment (DWP 2017a). **Abbreviations:** Work Choice (WC), Work Programme (WP).

Table 3 Ten Personal Adviser Role Dimensions

Personal Adviser role dimension	Statement of role dimension in relation to health
1. Assessor	Identifying claimants' health problems and related barriers to employment.
2. Counsellor	Listening to claimants' accounts of their health condition, and being empathetic.
3. Gatekeeper	Making decisions about which health-related interventions might be beneficial for claimants.
4. Enforcer	Identifying if a claimant has a 'good' reason for non-programme attendance and/ or engagement which relates to their health condition.
5. Enabler	Identifying appropriate work related activities that do not compromise claimants' health conditions.
6. Navigator	Identifying additional support options for claimants' non health-related problems which might impact on their health.
7. Seller	Liaison with employers to inform/educate about a claimant's health circumstances, and promoting types of jobs to claimants.
8. Advocate	Supporting claimants' illness perspective and reinforcing a 'not fit for work' message.
9. Health Promoter	Providing health-related advice to promote claimants' overall health in addition to the selling of the health-related benefits of working.
10. Health Monitor	Observing and questioning claimants about their general health.
NOTE: Role dimensions 1-8 were derived from the synthesis of earlier research findings prior to the Work Programme and confirmed during the new practice-level data collection involving the Work Programme and Work Choice. 9-10 were identified from the new empirical data which is presented in this paper.	

Table 4 Sample characteristics of the 11 claimants who took part in semi-structured interviews

Participant number	Self-reported ethnicity	Self-reported health condition	Sex
19	White British	Depression	Male
20	White British	Depression and anxiety	Female
21	Somalian	Depression and diabetes	Male
22	White British	Depression, anxiety and blood disorder	Male
23	White British	Depression and anxiety	Male
24	Asian Persian	Work related musculoskeletal injury-back	Male
25	Asian Persian	Arthritis and pain	Male
26	White British	Asthma and eczema	Male
27	White British	Terminal cancer	Female
28	White British	Cardiovascular condition and depression	Male
29	White British	High blood pressure /deaf	Male

Table 5 Key Health-related practice tasks performed by Personal Advisers as revealed by both direct observations and interview reports

Timing of programme	Practice tasks
Programme start	<p>Completing a formal assessment process.</p> <p>Gathering claimants' health-related information.</p> <p>Getting to know a claimant.</p> <p>Building rapport and trust.</p> <p>Interpreting claimants' health-related information.</p> <p>Identifying claimants' health-related barriers to employment.</p>
Pre work support	<p>Identifying and recommending health-related support interventions.</p> <p>Ongoing assessment in 1-1 and group activities.</p> <p>Liaison with other professionals.</p> <p>Action planning activities: agreeing and setting goals.</p> <p>Identifying job goals and suitable types of employment.</p> <p>Personally providing health-related support.</p> <p>Providing assistance with job search and job applications.</p> <p>Providing assistance with interview preparation and approaching employers on the claimant's behalf to discuss health problems prior to the interview.</p>
Post work support	<p>Identifying any in-work support needs e.g. reasonable adjustments.</p> <p>Monitoring and addressing any further or new in-work support needs.</p>