LEEDS BECKETT UNIVERSITY
SCHOOL OF HEALTH

Narrowing Inequalities through Connecting Communities with Health and Care Careers

Evaluation team: Dr James Woodall, Susan Coan and Ruben Muhayiteto

Centre for Health Promotion Research, School of Health, Leeds Beckett University

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Contact:

Dr James Woodall
Reader and Head of Subject (Health Promotion)
Centre for Health Promotion Research
School of Health and Community Studies
Leeds Beckett University
Email: j.woodall@leedsbeckett.ac.uk

Background

The links between secure employment and good career opportunities and health are well-recognised, with consistent reports in the literature of positive outcomes related to a myriad of health and social outcomes (Jonsson et al., 2021, Gevaert et al., 2021). Conversely, unemployment is a psycho-social stressor that has been linked to an increase in physical and mental health problems, low subjective well-being and quality of life (Peláez-Fernández et al., 2022). Socioeconomic inequalities remain prevalent in the UK and this is particularly damaging to fostering inclusive and cohesive communities (HM Government, 2022). These inequalities arise from a plethora of factors, but income and opportunity for developing education and skills in order to gain meaningful employment is a salient issue which if resolved could offer benefits for individuals and 'levelling up' wider society (HM Government, 2022). In short, employment is a clear social determinant of health for individuals and communities (Public Health England, 2015).

The Connecting Communities with Health and Care Careers programme, known throughout as 'the programme' or CCHCC, aims to work with communities in disadvantaged areas of the city which may also be under-represented in the workforce. Building on a successful programme of work in Lincoln Green (Woodall et al., 2022), CCHCC seeks to improve access to employment opportunities and provide practical support for people in their chosen career. Focusing on discrete communities in Leeds, the programme aims to remove barriers to recruitment and employment and provide the support that people need to succeed. The programme's rationale is to engage at local levels so that activities and opportunities are relevant. This includes identifying a career that's right for people and signposting appropriately to local vacancies or education and training courses.

CCHCC had two campaigns of work, detailed below:

Campaign 1 (July-Oct 2021): Armley and New Wortley	**Campaign 2 (Feb 2022-July 2022): East Leeds**
This campaign focused on recruiting local residents for Leeds & York Partnership NHS Foundation Trust's newly built Children and Young People's Mental Health Inpatient Service, Red Kite View. Candidates were also supported to access social care roles via Leeds City Council's We Care Academy and engage with further employability support.	This campaign focused on Clifton and Nowells, Lincoln Green and Boggart Hill. Learning from Campaign 1 highlighted that face-to-face communication in communities was essential. In response to this, local schools and community centres were accessed to enable direct conversations with residents. The people engaged were then referred for further support. As part of this campaign, work experience events within communities were held.

Adapted from: https://leedshealthandcareacademy.org/partner-workforce-hub/

In order to capture and distil learning from CCHCC, Leeds Beckett University were commissioned to independently assess the programme. This evaluation aimed to carry out a formative evaluation of the project with insight into the process and experience of programme delivery, both from the reflections of the professionals working and overseeing the programme and recipients of CCHCC's interventions. In addition, the evaluation assessed and analysed routinely gathered monitoring information and outcomes. A full outline of the methodology and analysis strategy is provided next.

Methodology

The approach to the evaluation maximised the benefits of qualitative and quantitative approaches to triangulate different data and sources. Quantitative monitoring data were received by the

evaluators via the programme team and descriptive statistics performed to understand patterns and trends. Qualitative information was also sought through those professionals working on the programme and those members of the community who had been participants. The suitable identification and sampling of both of these groups were facilitated by the programme staff.

Three focus group discussions were undertaken with professionals on the programme, with ten participants taking part. These participants encompassed a range of partners working on the programme and discussions were undertaken online for pragmatics. Participants on the programme from local communities were invited to participate in focus groups or one-to-one interviews. Five one-to-one interviews were conducted over the telephone and a focus group comprising of eight community members was conducted in-person in a convenient local location.

All interviews and focus group discussions were digitally recorded, and field notes taken at the time of the interview. Critical listening was undertaken on the recorded data and thematic summaries produced to outline cross-cutting issues and areas which would produce future learning for the project. The analytical process followed guidance outlined by Braun and Clarke (2013) in that after a period of data familiarisation, the data were coded for salient issues relating to the aims of the research; codes were combined and organised; and from these more substantive thematic categories produced. The themes were discussed between the research team and initially shared with the programme steering group to refine further and gain a greater 'sense-check' of the data.

Findings

This section thematically distils key ideas derived from interviews and focus group discussions with professionals central to the programme and recipients of the intervention. Where direct quotations have been used, they have been anonymised to protect confidentiality and preserve anonymity. In addition, data derived from the analysis of routine monitoring information gathered by the programme will be included where appropriate.

Shared programme vision

A wide range of professionals were involved in the strategic and operational oversight of the programme. It was clear from focus group discussions with these professionals that there was a clear and harmonious vision of what the programme was seeking to achieve. While partners had slightly different foci, understandably based on their role and affiliation, there were common themes which permeated the discussions.

Most salient was the notion that the programme was there to facilitate individuals furthest away from the labour market into employment, by minimising barriers and increasing opportunities of access. As a result of this, there was an intention of raising both aspirations and improving health outcomes within these communities through increased self-esteem and confidence. This was reflected further in discussion with community members who described the prestige of working in the NHS, but this was against a historic cynicism in some parts of the community of healthcare professionals. Participants engaged in this programme wanted to dispel myths about social care, hospitals and medicine to help family members access care. Being a good role model to children by working in an NHS role was also mentioned:

> *"I have a big family, my uncle and aunties, but most of them don't trust hospitals and nurses."*

From an economic perspective, there was a shared approach from strategic professionals to maximising 'local jobs for local people' and more broadly to upskill communities in the city.

Alongside this, there was also the recognition that the programme was not solely altruistic and widening recruitment would bring significant benefits to the employers who are faced with high numbers of vacancies.

Strategic buy-in

CCHCC partners described the strategic support for the programme and highlighted how this made the process of setting-up the programme easier. Strategic support was provided from all levels of the partner organisations and this was deemed to increase the likelihood of success within the communities:

> *"I have to give credit to my organisation that every time they were asked to amend an existing process, […] I got the approval."*

There was a will to do things differently within organisations, exemplified by one professional: "what could have been an enormous, elaborate process of permissions was basically just done through a few emails. It literally was that simple." The investment in a 'data controller' was also considered significant in streamlining data processes and measuring success.

Process and mechanisms of the programme

It was clear that previous pilot work in Lincoln Green, albeit smaller in scale in terms of partnerships, was seen to offer important learning that could be taken forward into CCHCC programme model. For example, within Lincoln Green participants described being interview ready and not necessarily work ready. Understanding the strengths and limitations of the Lincoln Green project was instrumental in developing work on CCHCC. Through 'flipping' the recruitment process to train people upfront the project enabled people to undertake role related tasks in a safe environment; enabling them to make an informed decision whether the role was eventually right for them. The interview questions were given upfront as part of pilot. The focus throughout was ensuring the role was right for the person and the person was right for the role - rather than applying traditional recruitment processes which have been identified as a barrier:

> *"If you think back to Lincoln Green, there was a mixed bag of commentary, so employers were like, 'yeah, they're really good, they understand our values' and then you had individuals that were like 'I feel interview ready but not work ready'. So, kind of taking that on board and moving that forward, flipping the recruitment process. Training up front enabled us to kind of reduce some of those barriers that people have experienced. So if you have been unemployed for a period of time….we're able to give you a character reference to kind of support that onboarding process. It also provides an opportunity for individuals to make an informed decision about whether the role's for them."*

The programme operated using a 'hub and spoke' model. In effect, the 'hub' was a central filtering process with data subsequently being passed over to the most appropriate partner. For example, if an individual was between 16-25 years and not living in the geographical area of interest their details were passed over to the Community Renewal Fund[1] (Healthier Working Futures team). If they were within this age group but lived in the campaigns targeted area, they were supported through the spokes detailed under CCHCC remit. This could include a whole myriad of interventions and support (i.e. Learning Partnerships course; Leeds Employment Action programme - Customer

[1] A Government initiative that aims to support the people and communities most in need across the UK

Services and You (BTEC in Customer Services); We Care Academy; Apprenticeship - Clinical Support Worker training programme; English for speakers of other languages (ESOL); NHS Cadets) to enable people to gain recognised qualifications or to support people to apply for roles and be ready for interviews should they be shortlisted.

The range of training and employment opportunities available were intended to make sure there was an offer for anyone who engaged with the programme. Most of the 'spokes' in this model were pre-existing programmes that CCHCC could refer into, thereby maximising the impact of the work across the city and avoiding duplication.

Natalie[2], for example, participated in the Apprentice Clinical Support Worker programme which lasted two-weeks. The course involved training on moving and handling, nutrition, law and regulations in hospitals. After the programme, Natalie had an interview for the apprenticeship programme. Sandra and Roberta attended a customer services programme after receiving a leaflet from their children's school about careers in health and care. They learned how to deal with customers, how to handle problems and also identified core values around equality and diversity. Most participants described positive interactions with the spoke activities – Christine noted:

> *"Everything was perfect, I really enjoyed myself."*

Community outreach and engagement were seen to be the key mode of raising awareness of the programme and in starting a dialogue with individuals. The justification for strong community engagement was to generate referrals into a range of different pathways depending on a person's needs and interests. Community 'word of mouth' was seen as a critical asset to increase referral and engagement – indeed, several of the recipients of CCHCC interviewed for the evaluation had heard about the programme this way – and participants reported how this was a salient aspect of the outreach work. Local businesses (cafes and shops) and local GPs were also keen to support spreading the word by putting up posters and publicising the programme. In addition, areas where the communities of interest to CCHCC gathered regularly were identified – including local shops and schools – and targeted communications were used to promote CCHCC. This included using flyers and having electronic devices, such as iPads, to register people immediately to workshops and other activities. Similarly, the 'HUGO' (Helping You Get Online) bus enabled people to have conversations with professionals who could support them. Anyone who wanted to know more were invited to an information session to discuss the pathways and opportunities that were open to them.

Events in the community areas were also used to highlight the range of opportunities within the health and care sector. Some of these events were specifically aimed at demystifying different jobs and articulating the various different career pathways to "get in, go on and go further" across numerous role such as finance, estates, cleaners, care support roles, personal assistants, pharmacy etc. Ava described her experiences of attending an event at Harehills. It involved being put into groups and going round different rooms and listening to people – each session provided a 'taster' of different professions across health and care. It lasted around 6 hours with a lunch in between. Ava reported that she was able to speak to people who were running the workshop and talk through available options. Ava spoke to a relevant professional about her interest in becoming a nurse and

[2] Pseudonym

was informed about an Apprentice Clinical Support Worker[3]. She went on a week's introductory course and is now waiting to hear about a placement.

Removing barriers to maximise opportunities

As described earlier, one of the aims of the programme was to remove traditional barriers to applying or engaging in employment opportunities. CCHCC worked practically to enable people to access support – this included providing transport costs through bus pass travel and by providing information sessions and advice during convenient times of the day. This was particularly helpful for those with children, or single-parent families who may have otherwise struggled to access sessions in the evening.

Some structural changes in the application process for jobs were also made, again to support opportunities for people. Obtaining sufficient references, as an example, from former employees could be challenging especially for those who had been unemployed for some time. To minimise this impact, training providers could provide character references instead. Other rules around recruitment practices were also reassessed and eased (e.g. requirement for DBS, formerly CRB, checks) to offer equality of access to job opportunities:

> *"[There is] an organisational debate around what is the value of a CRB check for people who are not actually directly patient facing, I mean caring for somebody. What actually is the value of a CRB check? […] What risk are you guarding your organisation against? And I think we might take a stance that's even more relaxed than what we've got at the moment."*

Staff and processes showed considerable flexibility and adaptations were made throughout in response to feedback and learning.

Outcomes and key successes

Within this section, both the quantitative outcomes and qualitative outcomes will be reported separately to provide the overall successes of the work and also the individual achievements gained from participants.

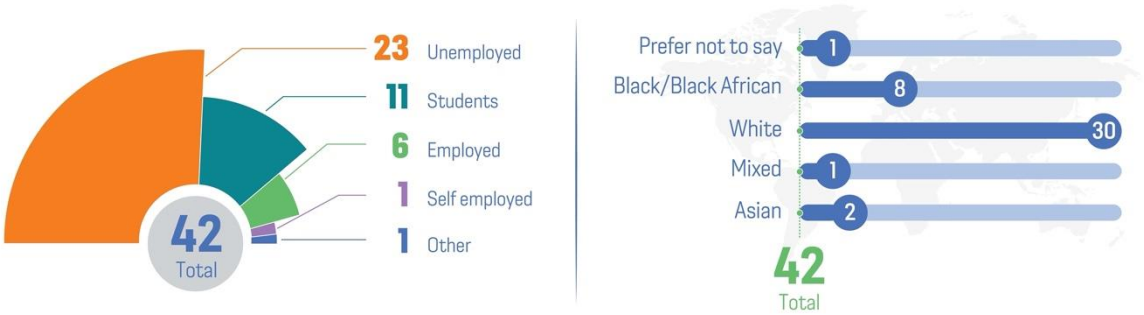
Quantitative synthesis

Overall, 548 referrals were received into the hub during the programme. Of these referrals, 152 were received from candidates within the target wards (Killingbeck & Seacroft and Richmond Hill & Burnmantofts). Unfortunately, 38 candidates from target wards were not able to be contacted after 3 attempts; 15 of these were from a priority neighbourhood (PN). Received referrals are below disaggregated into age ranges of candidates, their ethnicity and employment status.

Referrals received in 16-25 age-group were predominantly unemployed (23 representing 55% of all referrals received in same age-group). Candidates in employment (employed and self-employed) accounted for 17% and students represented 26% of referrals of the same age category. Candidates in this group were predominantly White and Black/Black African (71.4% and 19.0% respectively). It is important to note that 14 candidates in this age range were not able to be contacted after three attempts, and two other candidates withdrew from the programme.

[3] A supportive route available to anyone with no prior qualifications or experience. This programme is the first step on a career pathway where someone with no experience or qualifications can become a registered nurse within 7 years.

Figure1. Referrals within 16-25 age group, by employment status and ethnicity (counts)

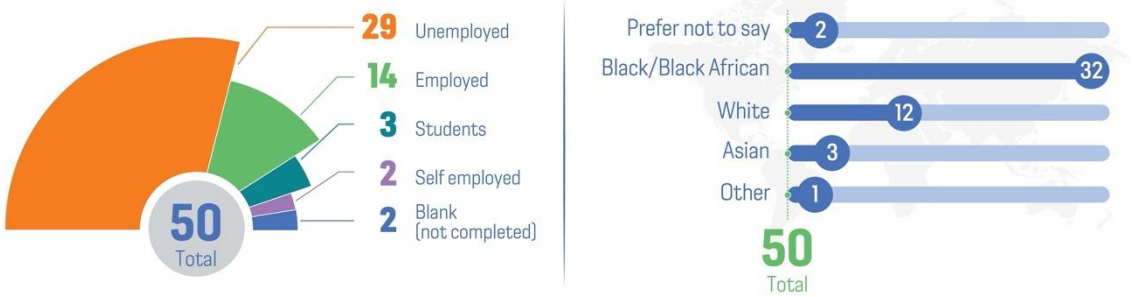


The referrals received for candidates aged 26-34 were 29 in total. These included 11 candidates who were in employment, 16 unemployed and 2 students. Black African was the most represented group in this age category (19 referrals).

Figure 2. Referrals within 26-34 age group by employment status and ethnicity (counts)

Fifty (50) referrals were received in 35-45 age category, with unemployed candidates representing slightly more than half of all referrals of this group. The programme received 16 referrals from candidates in employment (both employed and self-employed) and 3 students. In this category, 64% of referrals received were for Black/Black African candidates and 24% were White.

Figure 3. Referrals within 35-44 age range by employment status and ethnicity (counts)



Figures 4 and 5 both show the breakdown for participants in the two older age categories which had fewer referrals.

Figure 4. Referrals within 45-54 age group by employment status and ethnicity (counts)

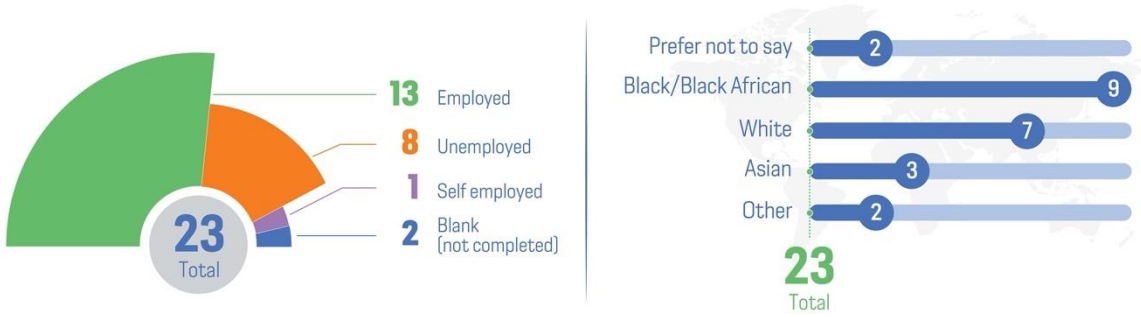


Figure 5. Referrals within 45-64 age group by employment status and ethnicity (counts)

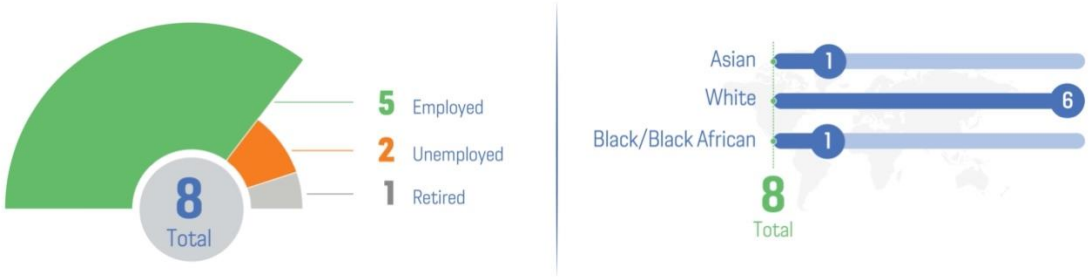
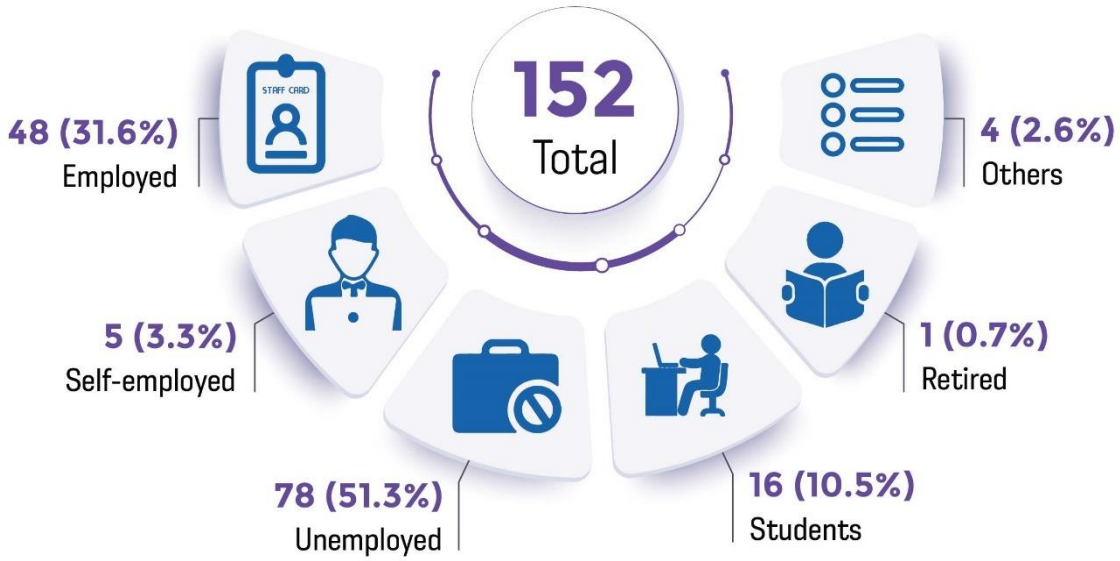


Figure 6 shows that of all 152 referrals received, unemployed people registered the highest percentage (51%), followed by employed people (32%) and students (10%).

Figure 6. Overall Referrals received by employment status (counts & %)



In relation to the overall aachievements of the programme

17

Covid vaccinations administered

49

achieved qualification

63

were offered conditional employment

- **Qualifications**

Forty-nine people achieved a qualification as part of this campaign (28 achieved a L1 BTEC in Customer services and 21 achieved a Level 2 Moving and Handling qualification).

- **Job offers**

Sixty-three (63) people have been offered conditional offers of employment - of which 36 have already started working across various partner organisations. Five people have withdrawn from the recruitment process following their offer of employment. Of those offered employment opportunities,

- 28 people live outside the areas of interest of the campaign, and are outside the criteria for CRF (i.e. older than 16-25 years)
- 25 people live within the neighbourhoods of interest
- 12 people fall within the CRF criteria - i.e. between the age of 16-25 yrs

It is important to highlight that of those who have been offered employment, 34 were unemployed, 5 were students, and 13 were employed (including people working on zero hours contracts).

- **Covid-19 vaccinations**

Seventeen vaccinations were administered during the programme partnership, with the help of Bevan Nurses.

Qualitative synthesis

Stakeholders of CCHCC were clear that while employment was a positive outcome, career development and opportunities and a carer pathway was a key focus:

> *"I think what's really important to remember from this piece of work and what was at the heart of the operational group was, we're not just talking about employment because employment alone does not reduce inequalities. What narrows inequalities is that opportunity to progress and carve out careers. So, although we did have a mixture of direct entry roles, we also had a variety of different apprenticeship roles to enable people to have that gaining experience and qualification to promote career progression. So what we're not*

here to do is offer people employment opportunities that potentially then gets them stuck at the lower end of the labour market and then therefore become trapped in that work poverty cycle. So as a team we made the collective decision not to talk about employment, let's talk about career opportunities and that came through in all our one to ones and kind of our contact with people."

There were a range of benefits and outcomes for those participants involved. Natalie described how the Apprentice Clinical Support Worker training programme allowed her to refresh her knowledge from past work experience , increase her confidence and widen her social network through meeting new people. The programme also enabled her to get a recognised qualification and supported her in updating and refreshing her CV. Sandra also received a qualification in customer services and Roberta found a new role that fulfilled her passion for learning:

"Every day I'm learning something and that makes me happier, you know, and I'm every day willing as well to learn a lot."

Ava shared how her confidence had grown through the training she had undertaken and how she felt better prepared for job interviews. Christine had similar experiences:

"It really empowered me, it has boosted my confidence. I can express myself now. So it's a whole transition and something for me now."

As well as employment and skills outcomes for participants which would enable career development, there were a range of other successes and positive impacts derived from CCHCC. There was some evidence that people in the communities of interest to CCHCC felt an increased sense of value given the investment and support that was being provided to them. This, in turn, increased aspirations for people getting into meaningful work opportunities or in enhancing existing talents and skills. Roberta, for example, was a single parent who wanted to develop her own skills and competencies so that she could increase her opportunities for employment to support her family. Such an outcome was regarded as being critical in parts of the city where people may have traditionally felt disenfranchised and 'left behind' in relation to the economic and skills growth agenda in Leeds:

"In terms of not just offering employment opportunity or career opportunities or education and training, I think that we've really connected with the vast majority of people to raise aspirations and inspire people to join the health and care system in one way or another."

The programme has opened up a talent pool for the health and care sector of the city, leading to greater diversity in relation to demographics but also backgrounds and expertise:

"I'm hopeful there's been outcomes already that we've seen in terms of engaging with a talent pool that we've not previously seen by traditional recruitment methods and particularly in Leeds community."

The 'flipped recruitment' model took less time than traditional recruitment and it was viewed favourably as a way of thoroughly preparing candidates for specific roles as well as reducing the burden on recruiting managers to screen and shortlist applicants. Staff were hopeful this could also help to improve retention of staff and to retain talent and expertise within the system rather within a single organisation.

Other wider city agendas were potentially being achieved through CCHCC. While greater levels of investigation and resource will be needed to demonstrate this, there was some hope that through

employing local people in local roles this will support the ambition of the city to be carbon-neutral by 2050 through reduced transportation emissions from employees travelling to work.

Lessons learned and future sustainability

Some of the interviews with participants identified that care is required when setting expectations for employment opportunities. Several participants spoke about not hearing back from opportunities that were discussed, or not receiving timely follow-up communication. Sandra, for instance, found the process somewhat frustrating and described how her mind was 'not settled' as a result of not knowing about placements and job starting dates. Her general sense that the programme was not as clear as it could be. Several participants discussed the frustration of 'post-intervention' follow-up and follow-through.

Some professionals that had worked closely on CCHCC made some suggestions in relation to the lessons learned during implementation and issues to consider for future sustainability. Such insight was indicative of a clear reflective process within the programme, with colleagues being honest in their assessment of progress and process.

A more strategic approach to community engagement and community communication was highlighted by some participants. This would include a clear plan for the future and a coherent strategy to ensure that all priority areas were reached.

Evaluating successes more routinely was also suggested as an appropriate way both to capture outcomes and identify good practice, but also to aid communication processes. Capturing vignettes, case studies and other experiences of local people involved in the programme was suggested to be useful to reinforce the positive aspects of CCHCC with local people and could also be used to ensure more buy-in from internal management.

Adequate funding and resource featured as a key priority for future sustainability as currently staff had deployment through their existing roles. A central resource dedicated to the programme would make sure it happened and did not move to the periphery or become side-lined when "reactive work" pushes out "proactive work". The impact of the work needs to be recognised with resources:

> *"It could be a dedicated resource in terms of delivery lead and additional support, whether that's project support or admin support."*

Ring-fenced funding would allow this model of working to be part of core business meaning that there is a consistent offer, and they could move away from the campaign approach which is particularly resource intensive.

Conclusions and implications

This evaluation sought to understand the processes and outcomes of CCHCC. CCHCC seeks to improve access to employment opportunities, but most importantly careers through, by providing the practical support for people in their chosen career pathway. It is very much a person-centred approach to recruitment. Evidence suggests a shared understanding and vision for the programme from those at the interface of delivery and strategic partners. While individuals had a nuanced focus and agenda for CCHCC, the understanding on the purpose was consistent and cohesive. Strategically, then, the programme was well understood and perhaps demonstrates the previous (pilot) work where lessons were learned (Woodall et al., 2022) clearly implemented in practice. The evaluation demonstrated that strategic buy-in from organisations was strong and that this lubricated processes and made things easier operationally.

The evaluation reports a series of positive processes that support the target communities, with 'word of mouth' being a powerful recruitment tool. Building trust and legacy within the communities of focus may see this mode of communication become more prominent. The 'hub and spoke' model gave opportunity for individuals to engage in a wide range of activities and programmes – the range of opportunities was impressive. The evaluation demonstrated a range of positive outcomes resulting from the programme – these linked to 'hard' outcomes, which included qualifications and employment but also improvements in confidence and self-esteem. The programme lifted the aspirations of many participants which was felt to have a ripple effect to others in the area. The programme staff had clearly worked hard, and were successful, in removing barriers to participation by creating conditions that promoted rather than reduced access to opportunities and events.

The evaluation did uncover some areas for consideration and where future focus could perhaps rest. These are listed here:

1. While participants of the CCHCC programme were almost unanimously impressed with the intervention and the support they had received and had a person-centred experience, several did feel let down that some actions had not been 'followed through'. This did lead to people feeling frustrated by employers and organisations.
2. Community engagement approaches could be more strategically considered to ensure maximum uptake and ensuring key target communities are aware of the possibilities the programme can provide. 'Word of mouth' and community mobilisation strategies seem a key strategy to harness future sustainability.
3. A continued focus on improving and learning was emphasised by strategic stakeholders, but how this translates into operational activities and meaningful routine data gathering was not clear from the data derived in the evaluation.
4. There are a myriad of outcomes as a result of CCHCC and yet some of these may not always be captured. A strategic review of the data gathered by the programme and how this can be used to support learning and evaluation would be useful.
5. Campaigns can be resource and labour-intensive. The evaluation would support the longer-term vision of embedding CCHCC as part of the city's long-term commitment to systematic change.
6. Resourcing the programme seems a fundamental consideration to ensure longer-term sustainability. A central, ring-fenced, dedicated resource to the programme could be highly beneficial.

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