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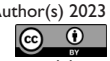

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Reducing health inequalities through skills training, support and removing barriers to employment

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Abstract

Objective: This paper reports on a programme which sought to engage individuals and groups who are underrepresented in the UK labour market. The programme aimed to improve access to employment opportunities and provide practical support in job applications. The focus was on encouraging people to seek employment in the health and social care sectors and on tackling health inequalities in the region.
Design: Qualitative inquiry.
Setting: Leeds, UK.
Method: Using focus groups and interviews, this paper explores key learning from the programme and the experience of programme delivery, both from the perspective of the professionals working on the programme and the individuals participating.
Results: A coordinated strategic partnership in which key agencies share a common purpose is critical. The value of a localised strategy to engage communities is an important mechanism for success. Working closely with schools and businesses provides opportunities to access individuals who might usually find employment services difficult to access. The programme examined here sought to put people's aspirations at the heart of delivery, offering choice and tailored opportunities to develop their careers. This could include developing specific skills or raising awareness of potential careers. The programme also promoted opportunities by removing barriers in the job application process. A range of positive health outcomes were reported for participants engaging in the programme that require further exploration.
Conclusion: Meaningful employment is an important health determinant, but some communities face barriers to employment and consequently find the labour market difficult to access. Findings suggest a range of ways to engage people in finding meaningful employment and support.

Keywords

Employment, health inequalities, health promotion, labour market, qualitative

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Background

This paper focuses on an employment programme in Leeds, a UK city, that sought to engage people in communities underrepresented in the labour market. The programme aimed to improve access to employment opportunities and provide practical support to people. Focussing on discrete communities, the programme aimed to remove barriers to recruitment and employment with the ambition of reducing health and social inequalities. The programme's rationale was to engage at local level to ensure activities and opportunities were seen as relevant. This included signposting appropriately to local vacancies or education and training courses allied to the health and care sector. Creating cities which are fairer and more equitable is a key principle of the 'Marmot City' – a concept pioneered by the work of Sir Michael Marmot to create a more equitable society, seeking to reduce inequalities through a range of approaches including fair employment; healthy and sustainable places and communities; and a healthy standard of living for all (Marmot, 2017; Munro, 2020).

Reducing inequalities in health and enabling people to take greater control of the determinants that impact their health is a cornerstone of health promotion philosophy (WHO, 1986). Health promoters must work across sectors, given that the issues that impact people's health are multifaceted and complex (Woodall and Cross, 2021). These inequalities arise from a plethora of factors, but an opportunity to develop education and skills to gain meaningful employment is a salient issue which if resolved could offer benefits for individuals and a 'levelling up' of the wider society (HM Government, 2022). Importantly, health promotion may have greater leverage when working in settings where 'health' is not the primary focus as most people's daily interactions take place outside of an illness service context (Lutz et al., 2019).

Meaningful employment is an important constituent of individual and community well-being and is a key social determinant of health (Marmot et al., 2020). Data show that in some economically and socially deprived areas, access to employment is a challenge and unemployment is high. The corollary to this is that health outcomes are poorer in these communities and inequalities are exacerbated rather than narrowed (Woodall et al., 2022). Unemployment can derive a range of negative health impacts such as stress, which can lead to an increase in physical and mental health problems, low subjective well-being and poor quality of life (Peláez-Fernández et al., 2022).

The health and care sector is one area where recruitment is needed to sustain high-quality services; however, there are continued shortages in some non-clinical areas of the UK National Health Service (NHS) such as Estates and Facilities (May and Askham, 2005). The NHS is currently carrying around 100,000 staff vacancies (Waters, 2022) and there are 165,000 staff vacancies in social care (Skills for Care, 2022). Therefore, supporting people to gain employment in this sector could be mutually beneficial. This is not the first attempt to facilitate employment in the health and care sector, with previous research showing the success of initiatives in providing skills, confidence and raising aspirations in specific communities to tackle health and social inequalities (Woodall et al., 2022).

Theoretically, at least, health promotion advocates acknowledge key benefits of working within settings such as communities, schools, prisons, universities and workplaces. Termed a 'settings' approach, this has provided operational benefits for improving individual and community health, but critically, there has been a failure to capitalise on the synergies between settings and then to 'join-up' settings so as to optimise health potential (Bauer, 2022). The programme outlined here strived to form better connections between health and care workplaces and community settings where employment was low and health and social inequalities high.

The programme operated on a 'hub and spoke' model. The 'hub' was a series of events in local communities which acted as a touchpoint for communities with the programme. Individual data

were collected here (i.e. demographics, postcode, etc.) and information gathered from these events provided a better sense of people's aspirations and hopes in relation to employment opportunities. From the hub, the individual was supported to reach the most appropriate 'spoke' for them which could include a range of pathways to training and support to enable people to gain recognised qualifications and/or to support people to apply for roles and be ready for interviews should they be shortlisted. Several spoke activities were existing interventions already offered in the city (e.g. employability support programmes), thereby avoiding duplication. The range of training and employment opportunities available was intended to make sure there was an offer for everyone who engaged with the programme.

This paper reports on the learning from the employment programme (Connecting Communities with Health and Care Careers, but referred to as the 'programme' throughout this paper) and seeks to provide insight into the process and experience of programme delivery, both from the reflections of the professionals working on and overseeing the programme and the recipients of the hub and spoke model. The programme was focussed on economically deprived areas of Leeds and work commenced in July 2021. The programme was led by Leeds Health and Care Academy – an agency designed to tackle workforce challenges in Leeds and maximise the opportunities that a joined-up approach could bring to tackling inequalities in health. The Academy is joint funded by the UK National Health Service and local government but operated as the lead delivery partner for this programme in conjunction with other partners such as learning and skills providers.

Methodology

Qualitative data were collected from professionals working on the programme and members of the community who had been participants. This occurred after the first year of the programme delivery. The data were collected and analysed by researchers (J.W. and S.C.) independent of the programme and who were commissioned to provide objective insight into the delivery of the work.

Purposive sampling was used to gain in-depth understanding of participants best placed to provide insights into the programme (Patton, 2014). The identification and sampling of the two groups of participants were facilitated by the programme staff. An email was sent from the programme team to both sets of participants in the programme inviting them to take part in the study. The contact details of those who accepted the invitation were then shared with the research team to conduct data gathering.

Three focus group discussions with professionals ($n = 10$) connected to the programme sought to explore their different perspectives on the project's objectives, its progress and delivery, and how it had or could reduce health inequalities. The participants encompassed a range of stakeholders from three NHS trusts, the City Council, the city college and a third-sector partner involved in training programme delivery. They were also asked to describe any outcomes observed and/or documented and key learning from the work. The discussions took place online using Microsoft Teams.

Sixty-five participants in the programme from local communities were invited to participate in focus groups or one-to-one interviews. The research team used a semi-structured interview schedule to enquire into their experience of participating in the programme, in particular what worked well, what could be improved and what impact the programmes was perceived as having had on participants' lives (if any). Five one-to-one interviews were conducted by the telephone and a focus group comprising eight community members was conducted in-person at a community centre in a priority neighbourhood conveniently located for participants.

All interviews and focus group discussions were digitally audio recorded, and field notes were taken at the time of the interview. Critical listening was employed to make sense of the recorded

data and thematic summaries were developed to outline cross-cutting issues and areas which would produce future learning for the project (Halcomb and Davidson, 2006). The analytical process followed that outlined by Braun and Clarke (2013). Following 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 were produced. The themes were discussed by the research team and initially shared with the programme steering group to refine further and gain a greater 'sense-check' of the data.

The study protocol was reviewed and approved by the School of Health, Leeds Beckett University ethics committee in advance.

Findings

This section details recurrent themes in the interviews and focus group discussions. Where examples are cited which draw from people's experiences, pseudonyms are used to protect confidentiality.

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 data that these professionals had a clear and relatively harmonious vision of what the programme was seeking to achieve. While partners had slightly different foci, based on their role and affiliation, there were common themes across the data.

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 the communities targeted by the programme through increasing self-esteem and confidence. The increased confidence was linked to a sense of pride which was reflected in discussion with community members who described the prestige of working in the NHS. However, some participants spoke about a historic cynicism in some parts of the community about healthcare professionals who were not always trusted or respected. Being a good role model to children by working in a health role was also an important motive for people, and in addition, some participants in the programme wanted to dispel myths about social care, hospitals and medicine to help family members access care. When Sadia's father passed away, for instance, his cancer was found very late because he was scared of going to the hospital. None of Sadia's family worked in health roles, but she felt that if she did, she could change perceptions of healthcare in her family/community:

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

From an economic perspective, a shared perspective among strategic professionals was the focus on maximising 'local jobs for local people' and more broadly upskilling communities in the city. Alongside this, there was also the recognition that the programme's goals were not solely altruistic since widening recruitment would bring significant benefits to employers who were faced with high numbers of vacancies.

Strategic buy-in

The programme partners described the strategic support that had been engendered by the initiative – fostered through historical partnership working between individuals and organisations – and

highlighted how this had made the process of setting up the programme easier. Strategic support was provided from all levels of the partner organisations (including the NHS, local government and training providers), and this was deemed to increase the likelihood of success within the communities. One senior NHS Manager stated,

> 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 strong commitment to make the programme work as the benefits for the city were manifold. There was a will to do things differently within organisations, exemplified again by views expressed by an NHS senior manager:

> what could have been an enormous, elaborate process of permissions [seeking] was basically just done through a few emails. It literally was that simple.

Process and mechanisms of the programme

The range of training and employment opportunities available proved very attractive to members of the local community. Natalie, for example, had participated in a pre-employment Apprentice Clinical Support Worker programme which lasted 2 weeks. She had previously worked in domestic care, but had stopped doing this for family reasons. She was now in a better personal situation to re-engage with employment and training. The course involved training on moving and handling, nutrition, law and regulations in care settings. 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 engage with customers, how to deal with problems and also identified core values around equality and diversity. Most participants described positive interactions with the activities they engaged with – Christine, who had been a carer and was now looking for employment, 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 beginning 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 means to increase referral and engagement – several participants had heard about the programme this way – and reported how this was an important aspect of the outreach work. Local businesses (cafes and shops) and local GPs were also keen to spread the word by putting up posters and publicising the programme. In addition, places where the communities of interest to the programme gathered regularly were identified, including local shops and schools, and targeted communications were used to promote the offer. This included using bespoke flyers highlighting the opportunities and potential offer, and having electronic devices such as iPads to register people immediately for workshops and other activities.

Events in the local communities were also used to highlight the range of opportunities within the health and care sector. Some of these events aimed to demystify different kinds of work and signal the different career pathways to 'get in, go on and go further' in various roles such as finance, estates, cleaning, care support, personal assistance and pharmacy. Ava, who was 19 years old and looking for a career in nursing, described her experience attending an event in one of the

local communities. Participants had been encouraged to form groups and go around different rooms listening to people – each session provided a 'taster' of different kinds of work in health and social care. Ava reported that she had also been able to speak to the people who were running the workshop and talk through available options. In the session, she expressed her interest in becoming a nurse and was informed about appropriate training opportunities.

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. The programme worked practically to enable people to access support – this included covering 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 particular jobs were also made, again to support opportunities for people. Obtaining references, for 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 (e.g. the requirement for criminal record checks for certain positions), to maximise equality of access to job opportunities. One of the professionals working on the programme suggested,

> [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 [criminal records] 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.

Outcomes

Stakeholders in the programme were clear that while employment was a positive outcome, career development, up-skilling and developing a career pathway were important too. One of the professionals involved in workforce development in the city commented,

> 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 by meeting new people. The programme also enabled her to get a recognised qualification and supported her in updating and refreshing her CV. Sandra, as mentioned earlier, 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 to enable career development, other successes and positive impacts derived from the programme. There was some evidence that people in the communities of interest in the programme felt an increased sense of value and self-worth, given the investment and support provided to them. This, in turn, increased aspirations for getting into meaningful work or 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. Professionals suggested that such an outcome was regarded as being critical in parts of the city where people may have traditionally felt disenfranchised and 'left behind' compared to other localities where investments had been made in relation to economic growth and enhancing skills within the community:

> 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 also 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. One of the professionals involved in the programme noted,

> 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 – providing training before people had been appointed – 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. Healthcare staff involved in the programme were hopeful this could also help retain talent and expertise within the NHS and social care sector.

Other wider city agendas were potentially being contributed to through the work of the programme. While additional resources will be needed to achieve the goal, there was hope that employing local people in local roles might support the ambition of the city to become carbon-neutral by 2050 through reduced transportation emissions from local employees travelling to work.

Sustainability

Evaluating successes on a more regular basis was suggested by the professionals as a way to capture outcomes, identify good practice and aid communication processes. Using vignettes, case studies and experiences of local people involved in the programme was felt to be a useful way of reinforcing the positive aspects of the programme among local people and could also ensure greater buy-in from strategic bodies in the city in health and local government through seeing the success.

Adequate funding and resources were seen as key to future sustainability as currently the professional staff contributing to the programme had deployment through their existing roles. A central facility dedicated to supporting the programme would make sure the work happened, but this would need to be recognised with dedicated resources. One workforce development professional noted,

> 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 way of working to become part of the core business meaning a more consistent offer and a move away from a campaign approach to something more sustainable.

Discussion

Creating healthy urban spaces to address inequalities in health is becoming a major priority nationally in the UK (Marmot, 2017; Munro, 2020). Increasing resources in health service delivery – through more hospitals, and better primary care services – is only part of the solution, with other settings critical in addressing pervasive health disparities. Meaningful employment is a key social determinant of health (Marmot et al., 2020), with evidence consistently showing that employment provides positive health and social outcomes (Gevaert et al., 2021; Jonsson et al., 2021). Data show though, that in some economically and social deprived areas, access to employment is a challenge and unemployment is high (Woodall et al., 2022). There are key drivers to changing this situation, including the 'levelling up' agenda in current UK political discourse which offers the possibility to make meaningful changes for individuals furthest away from the labour market (HM Government, 2022). Employment not only drives economic growth but also provides improved health through income opportunities and raising standards of living (Nayyar, 2014).

The programme this paper has described sought to challenge inequalities in health across different communities in Leeds, a major UK city. Through focussed attention on the needs of the local population and a bespoke approach to accessing people in their own communities, the programme was able to mobilise individuals to train and consider a career in the health and social care workforce. This is an important intervention not only to support those individuals and communities but also to support the health and social care sector in the city, which accounts for approximately 13% of the UK workforce (Anderson et al., 2021) and within which job vacancies remain (Skills for Care, 2022; Waters, 2022).

It is likely that many of the participants who engaged in the 'Connecting Communities with Health and Care Careers' programme had a range of reasons why they were not currently in work. These could include caring responsibilities and ill health. Despite this, the programme was cognisant of putting people's ambitions and aspirations at the heart of delivery, offering choice and tailored opportunities. As a health education and health promotion intervention, it was critical to do so and not assume there were quick and easy solutions to long-standing problems. Ultimately, this programme was not about filling vacancies as quickly as possible or addressing acute needs in health and social care. Such an approach can be counterproductive, given that precarious short-term employment can be detrimental to health outcomes (Lewchuk et al., 2008). Research demonstrates, for example, that social care programmes which open up employment opportunities can be criticised for offering only poor, short-term opportunities which are often poorly paid (Montgomery et al., 2017). In contrast, this programme actively tried to remove barriers to recruitment and find the right opportunities for the right people.

The shared vision among stakeholders in the programme was fundamental to its perceived success. A commitment to supporting those furthest from the labour market was key, with additional outcomes anticipated in terms of improved health and well-being in communities; and more people working in health and social care. A localised recruitment approach offers benefits and could be part of the long-term workforce development strategy currently needed in many sectors (Anderson et al., 2021), and especially in health and social care. In regard to improvements in health and well-being within communities, the study revealed improvements in people's confidence as a result of the programme. Opening up opportunities for people to work in health care support roles (e.g. facilities management) is an area that has been given relatively little attention in the UK. However, these roles comprise 40% of the workforce and therefore have a substantial impact on the efficiency of the health service and patient experience (Anderson et al., 2021).

The importance of evaluating and monitoring employment programmes which seek to reduce inequalities has been discussed previously (Woodall et al., 2022). The programme looked at in this study struggled to adequately measure and monitor success, but capturing this information will be critical to demonstrate performance and increase the likelihood of programme sustainability. Researchers and academics working in this field can support this by developing tools for measuring success within programmes.

Conclusion

Communities furthest away from the labour market are often to be found in areas that are deprived and disenfranchised, characterised by poor health outcomes and limited opportunities for social mobility (HM Government, 2022). Opportunities to access employment are often made difficult by systemic barriers and practical challenges (Woodall et al., 2022). This paper has reported on a health promotion programme which sought to remove those barriers and provide meaningful employment in the health and social care sectors of a UK city. Through a strategic partnership, with shared aims and a clear mission and purpose, and bespoke and tailored approaches to engaging discrete communities, the programme was able to demonstrate the value of a localised strategy to engage individuals and communities. Targeting local areas and local focal points through community outreach, provided an opportunity to reach individuals who might usually find other employment services difficult to access. While this study was not able to report comprehensively and in-depth on outcomes, there were clear health and well-being benefits to those who engaged and accessed the training and employment opportunities.

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