RESEARCH ARTICLE

Title: The community health apprentices project – the outcomes of an intermediate labour market project in the community health sector

Abbreviated title: The community health apprentices project

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Abstract

This paper reports on the outcomes of the Community Health Apprentices Project, an intermediate labour market project delivered in two neighbouring areas of Bradford, England. The project was illustrative of current UK policy in its attempt to both address unemployment and health inequalities. The aim of the paper is to improve understanding of the type and range of outcomes that can result from intermediate labour market projects based in the community health sector. A qualitative evaluation was undertaken and interviews were carried out with three groups of stakeholders: the community health apprentices, key informants in the placement organisations and the delivery partners. Findings show that both anticipated and unanticipated outcomes occurred in relation to increased skills for work, improved health and wellbeing and improved organisational capacity. While there are contextual factors which make this project unique, the findings illustrate the potential range of outcomes that can be achieved when social and emotional support is offered in tandem with work experience. The findings further highlight the organisational benefits of investing in local people to deliver community health work. The paper concludes that in order to build an evidence base for intermediate labour market approaches, a broader understanding of outcomes needs to be developed, taking into account social and health outcomes as well as economic indicators.

Key words: Intermediate labour market; health inequalities; community health work; health outcomes.

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Introduction

The current British policy approach to tackling worklessness and social exclusion has focused on providing work experience, training and skills development to enable people into work (e.g. Social Exclusion Unit, 2002; Department for Work and Pensions, 2008). Now found in many high unemployment areas, intermediate labour market (ILM) projects are an example of this approach. A central feature of these projects, which distinguishes them from other transitional employment initiatives, is that they are area based and there is social benefit from the work to local communities (Finn & Simmonds, 2003). ILM projects typically offer people who are most disengaged from the labour market, such as the long term unemployed and economically inactive, a period of temporary paid employment along with support and personal development (Parker, 2006). Marshall and Macfarlane (2000:5) summarise the main aim of ILM projects: *"to give those who are most removed from the labour market a bridge back to the world of work by improving participants' general employability*". The approach is reliant on creating additional employment opportunities, often of value to the community, rather than replacing existing jobs. An international review found that there were approximately 73 intermediate labour market projects operating in Britain in 2001/2, providing around 600 jobs (Finn & Simmonds, 2003). ILM's are generally associated with the Third Sector (Aitken & Spears, 2005) but can be successfully operated by a wide range of lead bodies (Marshall & Macfarlane, 2000). Although the jobs are created in all occupational categories, the majority have been in skilled construction and building, administration, caring personal services and customer service.

Previous research findings have suggested that ILM projects are proficient in engaging disadvantaged individuals in both training and employment (Parker, 2006) and various economic outcomes have been demonstrated. The evidence in this area is complex because of the issue of the sustainability of any employment achieved. However, American evidence demonstrates that programmes focusing upon a combination of skills development and education offer increased employment and earnings (US Congress, 1999). There is potential for supplementary outcomes to occur

at an individual level, such as skills development or increased confidence, in addition to economic outcomes. Given the area based focus, it can be surmised that change may occur within placement organisations and even lead to outcomes at a community or population level, but there is little research in this area. Greater understanding of the range of social and health outcomes that can result from engagement with this type of initiative is therefore required.

This paper reports on the qualitative outcomes resulting from an ILM project that was run in two neighbouring areas of Bradford in the North of England. The Community Health Apprentices Project is of particular interest because it was situated in the community health sector where few ILM projects appear to have run, and additionally had wider aims around increasing the capacity of local organisations to meet health needs. It is widely recognised that employment is a major determinant of health and therefore providing a route to work can impact directly on both the physical and mental of individuals and families (World Health Organization, 2008). Setting the project within the community health sector meant that there was potential to contribute directly to the health of the wider community through the inclusion of local people in the health and social care workforce. Indeed, the current UK public health agenda gives emphasis to the role that local people can play in supporting peers to reduce health inequalities (Department of Health, 2004). The Community Health Apprentices Project was predicated on an understanding that the new workforce would bring their own life skills and local knowledge to placements and thereby increase the capacity of those organisations to work effectively with local residents.

This paper presents findings from a qualitative evaluation of the Community Health Apprentices Project. The primary purpose of the paper is to improve understanding of the type and range of outcomes that can result from ILM projects based in the community health sector. Following a brief description of the project and the evaluation methods, themes from interviews with both the apprentices and key informants from community health organisations are presented. The discussion appraises the evidence and seeks to draw out implications for practice and research.

The Community Health Apprentices Project

The Community Health Apprentices Project was based within two neighbouring areas in the north east of Bradford, Shipley East and Newlands Plus. These areas are characterised by economic deprivation and relatively high levels of unemployment, combined with evidence of health inequalities in relation to major health indicators (Bland, Hodgson & South, 2003; City of Bradford Metropolitan Council, 2006). The project was developed and delivered in partnership by two local organisations; Health Action Links for Everyone (HALE), a Healthy Living Centre based in the Shipley area of Bradford, and Health on the Streets (HOTS), a Primary Care Trust Project in the Newlands Plus area of Bradford. Healthy living centres are small scale area based initiatives that were intended to address the wider social, economic and environmental determinants of health through the provision of a range of health related activities (Rankin, Truman, Backett-Milburn, Platt & Petticrew, 2006). HOTS, a primary care based project, had a similar remit to address health inequalities through the adoption of an empowerment approach, working with local communities to improve access and encourage appropriate use of services. Typical of ILM projects, the Community Health Apprentices Project was funded through multiple sources but predominantly through European funding. An earlier project, focusing only the Shipley area, had been found to have successfully provided supported employment to local people (McGregor & Barclay, 2005).

The two overarching objectives of the Community Health Apprentices Project were to enable at least seven people to gain permanent employment or access learning at the end of their placements through the development of transferable life and work skills and to enable at least six placement organisations to benefit from sufficient placement hours and support from the project to increase their capacity to address the health inequalities agenda. Apprentices were recruited from the immediate localities and there was a commitment to target people who did not traditionally seek work in the community health sector, such as members of minority ethnic groups and people with disabilities. The project ran between 2005 and 2007, in which time a cohort of 12 local people were recruited and placed in a range of community health organisations for an initial 18 month period which was later extended to 20 months. Table 1 shows the range of placements which included both statutory and voluntary organisations. In addition to

work experience, the apprentices were offered an induction and ongoing training on work and life skills development through the delivery partner organisations. Within the placements the apprentices were allocated a placement supervisor with whom they worked closely.

Evaluation methods

In evaluating community based interventions it is important to apply the principles of evaluation in a way which is consistent with the nature of activities, the local context and the underlying values of the project. Traditional experimental methods of establishing outcomes, such as control trials, are rarely suited to the evaluation of such projects (Potvin & Richard, 2001; O'Dywer, Baum, Kavangah & MacDougall, 2007). Green and South (2006) identify six elements of good evaluation practice in relation to community health initiatives, including measuring changes in both individual and community health, using appropriate evaluation methods and examining processes. The project had incorporated monitoring and evaluation into its remit and throughout the project the apprentices were encouraged to document outcomes through building up a portfolio. A summative evaluation was undertaken at the end of the project with the primary aim of investigating individual, project and community level outcomes for the different stakeholder groups. This evaluation took place between during the last three months of the project March 2007 – May 2007. An evaluation working group was formed to oversee the evaluation, with involvement from the university researchers and delivery partner organisations.

A qualitative methodology was adopted in order to capture the experiences and perspectives of those involved, as well as to establish contextual factors and to allow discussion of any unexpected outcomes (Patton, 1987; Parry-Langdon *et al.*, 2003). Gaining the views of several stakeholder groups enables evaluators to be more confident in terms of measurement of success (Koelen, Vaandrager, Colomer, 2001). In this project, the experiences of the health apprentices, the placement supervisors, as well as those involved in project management and coordination were sought (referred to as delivery partners). A qualitative approach was considered appropriate to elicit in depth insights into the impact of the project on the different stakeholder groups and to

allow the health apprentices to relate their individual journeys (Wisker, 2001). Individual semi structured interviews were chosen as a suitable method to allow participants to reflect on personal experiences occurring over the course of the project (Ackroyd & Hughes, 1992). Interview schedules were developed for each stakeholder group to explore the range of experiences from recruitment through to future plans.

In relation to the sampling strategy, it was planned to conduct individual interviews with all 12 community health apprentices and with all the delivery partners. Telephone interviews were to be conducted with a sample of supervisors in the placement organisations. In order to build familiarity and trust amongst the stakeholders the interviews were carried out by one researcher (KJ). Participation in the study was on a voluntary basis. Participants were given an information sheet and informed consent was obtained. Face to face in-depth interviews were conducted with ten of the twelve apprentices. Of the two that did not participate, one apprentice was unable to take part due to work commitments and the other was not contactable due to long-term sickness. In most cases the in-depth interviews took place in the interviewee's placement organisation and lasted up to an hour. Of a list of thirteen supervisors (some apprentices had two supervisors), telephone interviews were conducted with ten. The remaining were unable to take part due to time commitments. Face to face interviews also took place with the managers of the two delivery organisations, the original project coordinator and the two subsequent coordinators.

The interviews were audio recorded on a digital recorder and then transcribed verbatim. All the interview data were coded inductively to identify emerging themes, which were subsequently grouped into major categories and sub categories. Therefore, the analysis carried out was a circular process of describing, classifying and finally connecting (Dey, 1993) to discover regularities, variations and singularities allowing theory to be developed (Blaikie, 2000). The data from each stakeholder group was initially analysed separately because of the different perspectives of those groups. Comparison across the data sets was then undertaken to reveal common and distinctive themes and was undertaken by two researchers (KJ, JS). It was intended at the outset that as the intended project beneficiaries, the main focus of the evaluation would be deepening understanding of the experience of the individual apprentices. In reporting the findings, the divergence and convergence of perspectives regarding outcomes between

stakeholder groups is made explicit. Quotations are used to illustrate the themes but are anonymised.

Findings

The apprentices interviewed ranged in age from 19 to 54 years. Six had children under 16 years and three of these were single parents at the start of the project. Of the ten interviewees, all but one were female, and nine were white British and one was Asian. It was a requirement of the project that the apprentices were residents of the local area. This section presents findings on the individual level outcomes for the health apprentices. It starts by briefly reporting on the employment history and motivations of the apprentices, before moving onto to look at the economic, social and health outcomes. Findings on the wider impact of the project on communities and organisations are then presented.

Most of the interviewees had a history of job instability. At the beginning of the project four of the ten apprentices interviewed had been unemployed and six had been working part time hours in unskilled jobs in the service industry, care work, retail or bar work. With the exception of a recent school leaver, the interviewees who were unemployed prior to the project, had also previously worked in the service industry.

There was an interest in exploring the journey made by the health apprentices and interviewees were asked about their initial expectations and aspirations. A common theme to emerge about the apprentices' lives prior to becoming involved in the project was expressed dissatisfaction with their current situation, some describing 'being in a rut'. A minority indicated that they had already started to make changes prior to applying for an apprenticeship, such as taking up voluntary work. Commonly, the apprenticeship was considered an opportunity to build on existing skills and interests and to fulfill aspirations to work in and with the community:

> *"I've always wanted to work with families and young children. I'd always wanted to do that and that's why I went for it and it was local as well". (Community Health Apprentice 7)*

"I'd always worked in retail and I just thought I need to get out of this and I need to do something different and this was totally different. I always fancied working in the community and I hoped it would lead to something else". (Community Health Apprentice 6)

Skills for work

A primary objective of the project was to enable local people into employment. At the time of the interviews five apprentices had gained employment in the community health sector through the project, one was attending university and one was undertaking voluntary work. The remaining interviewees intended to pursue work in the community health sector. Project monitoring data revealed by the end of the project, eight apprentices had in fact gained employment in local organisations. Two apprentices had left before the end of the apprenticeship, one moving to further education.

One anticipated outcome of the project was the development of employment skills through the experience of work and through additional formal training opportunities. Apprentices had been encouraged to attend a range of training courses through their placement organisations. Furthermore, although a stipulation of funding meant that the project could not directly support NVQ training, two apprentices had gained accredited qualifications funded through their host organisations. Having an accredited qualification was recognized by the apprentices and other stakeholders as being very beneficial to improving employment opportunities:

"It were (my apprentice supervisors) idea originally, he said do you fancy going to college I wasn't really into it . . . , but he sent me because he's got a lot of contacts and that were it . . . he pushed me into it and here I am now . .. I can apply for a higher job. If you look in the paper there's this job here for £6 an hour for NVQ2 and then level 3 is like £9 - £10 an hour, it makes a difference when you think about it, a big difference". (Community Health Apprentice 1)

"I think they've learnt a lot and they've got a lot more skills but it's the evidence of that that's important for future employers." (Delivery Partner 1)

One apprentice, having gained a NVQ in her placement organisation, had started a social work degree. The apprentice attributed her decision to do the degree to the support offered by the placement organisation and the project.

A key outcome of the project was that apprentices had developed skills through their placements which would enable them to compete better in the labour market. For those people that had been unemployed for a long time, going back to work meant facing challenges around the day to day realities of work and developing routines. The apprentices perceived that they were better equipped through the apprenticeship to deal with issues such as developing time management skills, adapting to an office environment, and managing differences with colleagues. A number of supervisors reported that they faced a challenge to maintain a balance between giving the apprentices a real experience of work and ensuring that adequate support was provided. Time management was an area where significant improvement was seen.

In relation to key employment skills, both the apprentices and the supervisors spoke about the lack of confidence and nervousness exhibited around computers at the start of the apprenticeship as well as the development of IT skills. Most of the apprentices had limited IT skills at the start of the project:

> *"I didn't have a clue, I could switch it on that was all. I can now do Word, I can put in a report which is something I never thought of or dreamt of doing".* (Community Health Apprentice 9)

Developing skills to speak to groups had also been an area of concern. Delivering a presentation or having spoken in a meeting had been an important episode in building the confidence of interviewees:

> *"We had to get up in front of everyone and explain, and my heart was going ten to the dozen and my cheeks were flushed. I'm just that type of person I don't want to get up, but I think I've come a long way. I could have never done that at one stage but to get up now and talk a little bit about something, I've come a long way with that"* (Community Health Apprentice 8)

A major theme was personal development, with increased confidence and self esteem as the most commonly reported outcomes. All the apprentices reported gaining confidence from the start of the project to the end and lack of confidence was perceived to have been a barrier in the past. New found confidence was seen particularly in the areas of tackling day to day tasks within a work environment and mixing with professionals:

> *"I feel a lot more confident doing things, simple things like answering the phone or making a phone call to somebody and telling them about what's happening and where to meet etc".* (Community Health Apprentice 9)

The placement supervisors discussed that although it had taken a while to build the apprentices' confidence and self esteem, once it started to develop significant gains were made:

> *"She started achieving things and she suddenly got this major goal"*
> (Placement Supervisor 1)

> *"Later on she went down on her own and at that point she realised 'I can do this', visits on her own".* (Placement Supervisor 2)

The project was seen to have helped the apprentices to develop clearer career aspirations and goals. The interviews were conducted two months before the apprentices completed their placement. Understandably a number of apprentices expressed apprehension as they came to the end of their placement. The apprentices reported having gained interview practice and written c.v's with the support of the project. There was an increased optimism about interview skills. Some had attended interviews but even where they had been unsuccessful, having the experience of attending an interview was perceived to have been beneficial:

> *"I didn't get the job but I got narrowed down to two and they just said off the record the only reason the other girl got it was because she had a little bit more experience than you. I was very close to getting the job so I'm still confident . . ."*
> (Community Health Apprentice 7)

A common theme was one of expanded horizons. Some interviewees spoke of having greater understanding of what was needed to achieve previously held goals while others had consolidated earlier aspirations:

> *"When I've been working in care homes you do your job, you sit down and you chat to one of the residents and you get told off. So one thing I always knew was, I need a job where I can do that, and now working. . I'm not just caring, I'm doing something that's making a big difference in their lives",* (Community Health Apprentice 4)

Most continued to want to work in the community. One exception was an apprentice who had originally wanted to pursue community work but the placement experience had led her to choose an administration role. Overall, acquiring recent work experience and developing skills was seen as beneficial and putting the apprentices in a better position to apply for jobs. Typically interviewees described how far they had developed during the period, contrasting their confidence and future plans with their previous lives:

> *"Looking back now I've achieved a lot, so many things. I've had nearly two years experience now working in the community. I've been on loads of different courses, I've never had a CV before and I've managed to put one together. I've never been on a computer before and I did computers for beginners and I did more. I've learnt that much in such a short space of time. It's hard to say really. It's met my expectations and more in everyway".* (Community Health Apprentice 8)

Here the outcomes of the intermediate labour market project are shown to be crucial at an individual level. Seedhouse (2001) argues that work for health is basically enabling and therefore an outcome of this project was to benefit individual health via the process of enabling participants to achieve their own chosen goals.

Improved social situation and wellbeing

Using qualitative interviews allowed the apprentices to reflect on their personal journeys and the impact of participation on their lives. Many of the apprentices reported experiencing personal problems at the start of the project, such as relationship issues and debt, or problems arose during the apprenticeship. An unanticipated outcome was that the project had enabled some of the apprentices to manage and deal with personal issues, which could ultimately help their employment prospects. Again this is important in improving health, because better health can be achieved when individuals are able to overcome the obstacles that they face (see Seedhouse 1991). Indeed, it can be argued that because judgements of well-being are subjective (Seedhouse 1995), the participants' articulations of broader support in relation to subjective well-being must be reported as an important outcome of involvement with this programme.

Having the support of people to assist with personal finances was identified as beneficial by some. Furthermore the improved financial situation by being employed was mentioned by others:

> *"The pay is good, which in conjunction with help they were really good at sorting my finances out, what were mine, what wasn't mine".* (Community Health Apprentice 2)

The family friendly hours offered by the project, and community health work in general had allowed the apprentices to fit working around their family life. The flexibility and family friendly policies that working in the community health sector could offer compared to work in the service industry was perceived as a positive outcome. Many had not previously been aware that the opportunity to work in a family friendly way might exist.

Personal satisfaction gained through community health work was identified as a key theme. Interviewees' attitudes towards work had changed:

> *"I'm happy in what I'm doing. It makes a big difference if you're coming out to work.(before) I went to work where I did because it fitted in and my husband was the main bread winner, so that job fitted in well. I didn't*

particularly enjoy it. Where as this is something I've enjoyed and I'm passionate about." (Community Health Apprentice 9)

Some of the apprentices reported having suffered periods of depression or anxiety in the past. There were personal benefits reported in relation to mental health in terms of being less stressed and more confident:

"I'm a lot more chilled out than when I was working at […..] and you've got to be there at a certain time and finish at a certain time. So I think as my life as a whole it's been beneficial". (Community Health Apprentice 6)

A further theme was the effect of working within the health sector in terms of raised awareness of health issues and the importance of the adoption of health lifestyles:

"I've learned a lot about my own health, I've not lost any weight but I'm more aware of what's in so many foods or what you doing exercise wise and how to make yourself feel good. I've changed a lot in our lifestyles" . (Community Health Apprentice 4)

Some of the apprentices reported improvements in their health, for example, losing weight. The apprentices' own improved health and increased awareness was seen as having a direct effect on families with promotion of healthy lifestyles:

"You think more consciously and healthily. So it's not only affected me it's affected my kids as well because they have seen how I'm doing it so they're getting healthier now". (Community Health Apprentice 7)

A further impact on families was identified as a number of interviewees reported improved relationships with family members through being involved:

"I was quite aggressive and I do believe that [the project] has changed me for the better and made me have better relationships with family and friends. I've actually got rid of a lot of things I don't need. My relationship with my son has improved …". (Community Health Apprentice 4)

"My husband thinks I'm a different woman! So it has had a big impact at home definitely". (Community Health Apprentice 9)

Improved organisational capacity

The interviews explored the broader impact of the Community Health Apprentices project with the different stakeholder groups. Placement supervisors described a variety of motivations for originally taking on an apprentice. Expectations had been positive and concerned the potential benefits both to the organisation and the apprentice. A couple of the supervisors expressed a personal desire to share skills in their current role:

"It would be a real enhancement to my role and I'd like to be part of making that difference to somebody else's life". (Placement Supervisor 2)

Interviews with the placement supervisors provided strong evidence that through hosting an apprentice, the project had increased the capacity of local organisations to address health inequalities. On a basic level, an additional member of the workforce meant that organisations had extended or enhanced service provision. For example, projects were established that organisations would not otherwise have had the capacity to develop or projects were kept running when permanent staff were on holiday. A significant outcome was that the placement organisations had greater capacity to reach local communities, including those deemed 'hard-to-reach'. Apprentices reported how members of the community had sought their advice rather than that of professionals working in their organisations. Some placement supervisors perceived that their personal skills had been strengthened during the project by working so closely with members of the community. All stakeholder groups recognised the value of the apprentices as local people able to draw on personal skills, experiences and empathy to engage other members of the community into the activities of placement organisations:

"She has a natural rapport with people . . . and is very affable and easy to talk to, people naturally warm to her . . we ended up with three times as many people on the walks than when I tried to set that up because

she has a way of talking to people. . . it's a skill that can't be taught" . (Placement Supervisor 3)

"They're good role models and can just relate to people. They don't go in telling people, they go in listening and can empathise and people feel comfortable with them". (Delivery Partner 2)

"When people bring children in, with having a disabled son myself, I generally know where they are coming from and I know a lot of the problems they have and I think sometimes that helps. I can see and help in that way and just looking at things from that perspective". (Community Health Apprentice 5)

Both the apprentices and the supervisors reported gaining greater understanding of wider health inequalities through being involved with the project. The apprentices typically reported increased understanding of community needs and also better knowledge of social problems that existed within communities:

"I think a lot of it in the community is people getting together, there's a lot of isolation out there and other barriers, so I'm definitely more aware of stuff". (Community Health Apprentice 3)

The community language skills of one apprentice had been seen to be helpful for the placement organisation, but in addition other apprentices spoke of increasing their knowledge of minority ethnic communities:

"Everyone is ignorant to certain cultures and I was. Since working with [colleague] and going out into Asian families and communities that has just opened my eyes totally . . .and getting more understanding about Eid and their religion." (Community Health Apprentice 7)

A strong theme was the personal satisfaction that community health work could bring and the impact of that work on service users. One interviewee gave an example:

"There were a lad who came six months ago and he just sat with his head down all day but now he's like cracking jokes and taking the mickey

and getting stuck in and it's brilliant, it's absolutely brilliant to see something like that. You know that you're doing your job properly. I love that about the job, I love it". (Community Health Apprentice 1)

As well as increasing the employability of individuals, the project increased the numbers of individuals living in the two areas with skills in community work. Apprentices were seen as potential role models for other members of the community in terms of their outlook and approach:

". . . there is a lot of local low paid, insecure employment and . . . we would like to see local people achieve more. They could be seen as role models for local people to say actually there are other things you can get into". (Delivery Partner 2)

The apprentices perceived that they had grasped and adopted the principles of community health work. One explained how the importance of understanding the policy context on funding. Another apprentice talked about becoming involved in their local community and activism around housing:

"I've met people who work for housing and they help with arrears and sorting them out, I've got good contacts where I can go in and speak to them and …..that's why I've got involved in the action group as I know I've got the contacts. I want to try and help people if I can. It's nice to give back." (Community Health Apprentice 4)

Furthermore, it was recognized by the interviewees from the placement organisations and delivery partners that in some cases the project had strengthened existing relationships and forged links between local groups and organisations.

Discussion

The Community Health Apprentices Project had dual objectives around increasing employment through acquisition of transferable skills and increasing the capacity of organisations to address health needs through broadening the workforce.

The findings indicate that the project was successful in terms of the key indicator of employment status, thus improving the economic situation of individuals and their families as well as contributing to the economy of the local areas. In addition to gaining employment, the individual journeys of these ten interviewees over the 18 month period demonstrated significant personal change. A potential limitation of the study is that no baseline data were collected, other than that regarding the apprentices' prior employment position and there was reliance on retrospective accounts. The timing of the interviews may have led to more positive views being expressed, and though some interviewees did voice concerns about future prospects, it would have been useful to have conducted additional follow up interviews after the end of the project. In qualitative research, rigour is achieved through the generation of 'authentic accounts' (Seale & Silverman, 1997). In this study, the use of qualitative methods enabled in depth reflection on lived experiences and rich data were gathered from the apprentices. Findings from those involved in supervision and support triangulated with the emerging themes from apprentice interviews.

Overall the results not only provide additional evidence of the effectiveness of ILM initiatives (Marshall & Macfarlane. 2000) but also confirm the efficacy of an approach that is based on skills development and work experience to improve employability (US Congress, 1999). It is noteworthy that the community health apprentices were able to recognise their own skills development in key areas such as IT skills and also acknowledged the value of exposure to work culture and practices. A particularly significant finding was the theme of increased confidence and self esteem. These softer outcomes, better described under the umbrella of personal development, are important stepping stones in development work irrespective of economic indicators because they add value to both individual skill levels and arguably increase the ability of individuals to navigate a range of social circumstances, including job seeking. Some initiatives do not achieve the 'hard' outputs set out on paper yet they most certainly will have made some sort of progress. Wainwright (2003) calls this the 'distance traveled' and argues that such progress can be seen as stepping stones en route to the hard outcomes. Such stepping stones are achievements and therefore are measurable alongside quantitative outputs. Indeed, social psychological factors, such as self esteem, can be neglected in employment policies and schemes. Confidence levels are frequently very low for people that have been unemployed for long periods of time or who have had periods of job

instability (Dutton, Warhurst, Nickson & Lockyer, 2005), and the findings here suggest that building confidence was a key element in the success of the project. This is important for health gains in that the health apprentices developed both skills and experience that enabled them to become more autonomous. Hence, these individual outcomes can be seen as health gains when health is viewed as the set of foundations necessary for personal achievement (see Seedhouse 1991). Consequently a programme such as this has relevance for health as it allows obstacles to labour market participation to be removed, as well as enhancing educational gains via skill enhancement.

People that have been long term unemployed are more likely to suffer from personal, health and lifestyle problems (Dean, MacNeill & Melrose, 2003). The apprentices reported a number of personal and health problems at the outset of the project. Support to deal with these problems was made available through the project, including advice about managing debt, childcare and mental health issues and thus the resolution of these problems was an important outcome of the project. There is a debate concerning whether British welfare to work policies actually prepare people for long term stable employment (Kemp & Neale, 2005). One major implication of the evaluation is that interventions aimed at reducing unemployment need to address social and personal support as well as providing work experience and skills training. Furthermore, the family friendly opportunities offered by community health work were seen to contrast with experience of the service industry, which was prominent in the target areas for the project. While retail work is often framed as offering family friendly hours it may not offer the types of flexibility that mothers of young children require, such as the flexibility to respond to unexpected events (Dutton *et al.*, 2005). It is increasingly being suggested that jobs that allow people greater autonomy and control over their work and working hours to fit around their family and other life commitments are likely to reduce stress (Hill, Jacob, Shannon, Brennan, Blanchard & Martinengo, 2008).

The ability of community based interventions to reduce health inequalities has been widely disputed (O'Dwyer *et al.,* 2007). Notwithstanding these debates, there is evidence that the project had a positive effect on the health and wellbeing of the

participants and their families. Given that well-being is best described as a subjective experience (Seedhouse 1995), the participants' articulations of improvements in this area are an important outcome of this project. Given the scale of area disadvantage, it is unlikely that small scale interventions, such as the Community Health Apprentices Project, will achieve a reduction in health and social inequalities at population level. Only structural changes are likely to lead to a profound and lasting shift in health indicators (Catford, 2002; Raine, Walt & Basnett, 2004; Rae, 2006). It is argued, however, that interventions which seek to address the social determinants of health such as poverty and unemployment at an individual level can have value in terms of reduction of stress (Abbott, 2002). The evaluation was able to illuminate the impacts occurring from a change in social circumstances on individuals' mental health and on the quality of relationships. Of interest was the suggestion that increased job satisfaction from working in the community health sector may have been a more significant factor than improvement in finances. A further finding of relevance was the impact on the apprentices with regards to increased awareness of health issues and the adoption of healthier lifestyle choices. These reported changes were linked directly to the experience of work in community health settings. There is insufficient knowledge about the impact of employment in this sector on health and social outcomes, particularly with non-professional jobs, but a recent report points to a range of benefits for volunteers who become engaged in this type of work (Neuberger, 2008).

The evaluation findings uncovered a range of social and health outcomes resulting from involvement in the project and these have been grouped in Table 2. Further research would be required to examine if these outcomes related to the type of placement or to other contextual factors. Understanding and modelling outcomes is essential for the evaluation of public health interventions (Nutbeam,1998). The outcomes identified through the study were, in temporal terms, proximal to participation in the project, yet short term outcomes such as increased confidence and self esteem were sustained throughout the project and were perceived to be linked to improved coping skills and raised aspirations, and conceptualised as important health outcomes in their own right. Other intermediate outcomes, such as increased employability or lifestyle changes, can be mapped against the wider determinants of health and health behaviour (World Health Organization, 2008). Overall the results improve understanding of the potential benefits for individuals entering the workplace after an absence or for those

entering secure employment for the first time through ILM projects. Further research is needed to investigate whether the community health sector offers a uniquely supportive environment or whether these outcomes will be replicated in other sectors.

The study identified a number of organisational outcomes for placements and these were directly related to the overarching aims of the Community Health Apprentices Project to increase capacity to address health inequalities (Table 2). The project used the apprenticeship as a mechanism to allow community based organisations to draw on the skills and knowledge of local people. 'Support from next door' has been cited in current health UK policy (Department of Health, 2004) as a way that local people, through their understanding of neighbourhoods and their empathy, can help disadvantaged groups. The model of the Community Health Worker, drawing individuals from the target community to form part of the community health workforce, is common in international contexts, both in developing countries (Lewin *et.al*., 2005) and in North America (Swider, 2002) but has not been adopted extensively in the UK. The rationale is that the actions of peers who share an attribute, such as ethnicity or age, or bring experiential knowledge will act as a bridge between the community and public services (Rhodes *et al.*, 2007). This study provides some evidence that the added value brought by the apprentices helped local community health organisations not only to reach more residents within two disadvantaged areas but also to improve the quality of that engagement. Here the programme arguably contributed to bringing people together who would not normally mix, culminating in the production of both bonding and bridging social capital. Bonding social capital is produced when individuals have a common identity within groups (Jochum, 2003). Bridging social capital refers to the weak connections between people such as business associates and acquaintances (Jochum, 2003), Narayan (1999) pays particular attention to the potential for less powerful and more socially excluded groups to benefit from bridging ties, arguing that effective bonding and bridging ties are required to avoid social exclusion. Thus, the generation of social capital in this context is positive as it strengthens engagement with socially excluded members of society.

The current UK context supports the broadening of the public health workforce and recognises the public health roles of unskilled and semi skilled workers (Public Health Resource Unit & Skills for Health 2008; Department of Health, Undated). The

study findings would suggest that in order to embrace the benefits of employing local people, who through their lack of skills, education or work experience, are on the margins of the workforce, there needs to be adequate support and a focus on personal development, which in turn will impact positively upon health by enabling people to develop their potential to become more autonomous. A critical perspective should, however, be maintained concerning the structural inequalities and the pervasive effects of social class combined with inequalities around gender, ethnicity and age. Levenson and Gillam (1998) comment on how minority ethnic link workers recruited in the health service for their community knowledge and language skills can still lack equal access to health careers. Without the support and protection of a ILM project, individuals may continue to be marginalised in the workforce.

Conclusion

The Community Health Apprentices Project, as an ILM project in the community health sector, had two clear outcomes in terms of increasing employment and reducing health inequalities. The purpose of this paper was deepen understanding of the outcomes arising from the project both at the individual and organisational level. The impact of setting the project within the community health sector is of interest due to the limited research in this area but may ultimately limit the transferability of the results to other sectors. Nonetheless, qualitative research can extend knowledge of the range of potential benefits arising from these type of projects. Our central argument is that a broader understanding of the outcomes of ILM projects needs to be developed. There is evidence that participation may result in outcomes relating to personal development, social skills, the adoption of health protecting behaviours and broader health outcomes, in addition to more traditional economic indicators of employment and skills for work. Furthermore the organisational level outcomes can be significant for community organisations attempting to tackle health and social issues within disadvantaged neighbourhoods. Broadening the workforce through ILM initiatives represents one method to achieve greater engagement with local populations. Mapping outcomes can enable improved evaluation of such initiatives and ultimately recognition of the added value gained. Koelen *et al*. (2001) argue that in the evaluation of community based initiatives it is important to consider the long term impact of the project as well as short term gains. It seems likely that a legacy of the Community Health Apprentices Project

will be a number of sustainable projects and increased capacity to reduce inequality. Further research is needed to expand the evidence base on the health and social gains resulting from ILM projects and also to further investigate contextual influences on outcomes.

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Table 1: Description of the placement organisations

Type of Placement Organisation	Description of placement
Healthy Living Centre	A health living centre working with people of all ages to tackle health inequalities through community based projects.
Mental Health Project	A community project delivering workshops to enable people with mental health issues to develop self-confidence and skills.
Community Project affiliated to local church	A community centre with a range of various activities including a computer café for local residents.
Disability Equipment Project	An independent charity offering information and advice to people with disabilities and carers of all ages.
Area Coordinators Office	A council office working in partnership with any agency or group of young people to provide or improve services for young people.
Community based employment support project	A project supporting unemployed people to return to training and employment.
Social Services funded day centre affiliated to local church	A community centre running a social programme for socially isolated elderly clients.
Community based primary care team	A primary care team working with people across the full age spectrum using a community development approach based in three localities.
Walking project	A project focused on walking promotion activities and walking groups for people who are sedentary or at risk of heart disease, diabetes and obesity.
A local Sure Start Programme	A local programme providing integrated support to families with children under four years old.

Table 2: Benefits of participation in the project

Individual level benefits for participants	**Benefits to placement organisations**
Increased confidence and self esteem. Skills development e.g. computer skills, presentation skills and health work skills. Increased knowledge related both to individual health and community health needs. Personal development through training and work experience. Changes in own health behaviour e.g. adopting healthier eating Work experience and further employment opportunities Improved social relationships – within families and through wider networks	Added capacity in terms of delivery A variety of experiences added to the work environment Different understandings and relationships with clients – more holistic on occasion. Local connections and knowledge – grassroots approach is valuable for engaging with local people. Building partnerships and local networks via participation.