Disability Workforce Development
Te Pou o Te Whakaaro Nui

Promoting training uptake and completion in home and community support services

Focus on Māori, Pacific and rural support workers in Ministry of Health disability support services

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An overarching objective of the Ministry of Health's (MoH's) *Disability Support Services Two Year Work Plan 2011-2013* is improving the accessibility and sustainability of training for workers in the disability sector. This project aimed to develop a better understanding of barriers and enablers to effective workforce training for home and community support workers (HCSWs) in small MoH funded home and community support services. A key focus was on identifying factors supporting the successful uptake and completion of the National Certificates in Health, Disability and Aged Support level 2 (Foundation Skills) and level 3 (Core Competencies) qualifications for Māori, Pacific and rural workers.

Providers who participated in the research were selected based on the following criteria: those who had accessed the training grant scheme administered by Disability Workforce Development (DWD) within Te Pou; represented diversity in location (focus on rural and provincial); Māori and Pacific providers; agency size; and covering all national regions. Due to practical constraints, ten home and community support services supporting fewer than 1,500 disabled people funded under a MoH disability support services contract were identified and their training staff personnel interviewed.[1]

Summary research findings

Workforce training barriers are well known and include lack of formal qualifications, organisational infrastructure to support sustainable workforce training and development, and indirect training costs such as travel for those based in rural areas. In addition, HCSWs are often employed to deliver services to a range of clients (for example, accident and injury, older people aged over 65, and disabled people), meaning they may be funded through a range of contracts, which may or may not entitle them to access MoH workforce development funding.

A number of organisations have implemented a range of strategies to encourage formal training including making training mandatory, communicating training benefits, offering financial incentives, and encouraging attendance at recent training graduate ceremonies. The level 2 and 3 qualifications were seen as largely appropriate in both content/coverage and size of modules. However, improving training materials to include less academic and more culturally relevant examples of 'culture and *tikanga* Māori' and the diversity of Pacific cultures may go some way to supporting successful training completion.

[1] Most commonly the human resource, quality or training manager. The general managers of two providers were also involved in two interviews.

Findings indicate that effective workforce training, which involves successful uptake and completion of formal qualifications and leads to positive changes in service delivery, largely depends on having the following three aspects well addressed:

- a sustainable and well embedded training infrastructure
- relevant training content and its delivery
- the level of learning motivation and confidence amongst trainees.

Recommendations

Key recommendations made to support future participation in and completion of formal qualifications by Māori, Pacific and rural HCSWs in small MoH funded home and community support services include:

- **Ministry of Health**
    - working with other relevant funders of home and community support services to develop integrated contracting policies so that HCSWs employed by organisations in multiple services/roles can better access training to address their workforce development needs
    - continuing to prioritise the uptake of formal qualifications for the Maori, Pacific and rural workforces in home and community support services in the updated disability workforce action plan
    - working jointly with other government agencies to explore ways of incentivising workforce training for HCSWs
- **Careerforce** reviewing level 2 and 3 training materials to reduce duplication and to include less academic and more culturally relevant examples of 'culture and *tikanga* Māori' and Pacific cultures
- **New Zealand Home Health Association** taking the lead in:
    - collaborating with key stakeholders to develop career pathways for HCSWs and build HCSW as a profession
    - hosting a resource which maps out key organisations and resources available to support workforce training
- **Te Pou** taking the lead in:
    - disseminating information on training outcomes in an easily accessible way
    - updating and promoting the disability training directory to providers
    - clarifying the criteria, application requirements and timeframes for all grants administered
    - providing more hands-on workforce planning and development support to providers
    - promoting the leadership development grant as a means of up-skilling trainers and assessors
- **MoH funded home and community support services** creating positive learning environments and demonstrating their commitment to workforce training.

Background

Policy

An overarching objective of the Ministry of Health's (MoH's) *Disability Support Services Two Year Work Plan 2011-2013* is improving the accessibility and sustainability of training for workers in the disability sector. To achieve this, the plan identifies the need to ensure suitable training is available to smaller home and community support services, especially for Māori, Pacific and rural workers.[2]

Home and community support workforce

A survey undertaken by the New Zealand Home Health Association (NZHHA) in 2011 examined the workforce profile of its member organisations.[3] The survey found the vast majority (86 per cent) of workers were home and community support workers (HCSWs)[4] and their characteristics are summarised in Table 1.[5] The NZHHA survey and other research indicates Māori and Pacific peoples collectively represent about 20-30 per cent of the home and community support workforce.[6] Based on figures available from Statistics New Zealand (n.d.), Māori represent a larger portion of the general workforce in Gisborne, Northland, Bay of Plenty and the Waikato regions. Pacific peoples are most likely to live in the Auckland and Wellington regions. Areas with a large rural population include the Northland, West Coast, Tasman, and Waikato regions. It is expected these general population characteristics are also reflected in the home and community support workforce.

Outcomes

Earlier work undertaken as part of the Quality and Safety project found inadequate training was a high risk issue for home based support workers (Health Workforce Advisory Committee, 2006). Achieving quality support services is dependent on having a stable, well trained and committed workforce (Health Workforce Advisory Committee, 2006). Developing the knowledge and skills of Māori, Pacific and rural workers in home and community support services will contribute to consumers receiving safe and quality support. It will also aid improved workforce retention and in attracting people to work in the disability sector. Increasing the capability

[2] Māori and Pacific workforce development and building the cultural competency of mainstream support services are also key actions identified for providing better support and more responsive services in both the Māori and Pacific disability plans – *Whaia Te Ao Marama: Māori Disability Action Plan 2012-2017* and *Faiva Ora: National Pasifika Disability Plan 2010-2013.* The *Tertiary Education Strategy 2010-2015* also has a focus on and aims to maximise educational opportunities for Māori and Pacific peoples, and people in remote areas.

[3] The survey had 20 responses from 41 potential organisations (49 per cent response rate).

[4] Three per cent administrative coordinators, three per cent home support coordinators, six per cent nurses and one per cent managers.

[5] The New Zealand Disability Support Network (NZDSN) also surveyed members in 2011 and found 72 per cent of the workforce were females, the majority were aged 36+ and were more likely to be Pakeha, and that organisations with a high proportion of employees identifying as Māori, Pacific or Asian tended to be focused on providing services to these clients.

[6] The NZHHA (2011a) survey indicates 12 per cent of the home and community support workforce are Māori. While the survey also found Pacific peoples comprised 18 per cent of the workforce, this may be an overestimation given those who took part in the survey. Across the disability sector, Pacific peoples have been estimated to make up less than 10 per cent of the workforce. For example, data collected by the Health Workforce Information Programme suggests Pacific peoples reflect eight per cent of health and welfare support workers. The Quality and Safety project also found just over three per cent of support workers identified as Cook Island Māori, Samoan, Tongan or Nuiean.

of the Māori and Pacific workforces may also assist in reducing health inequalities, improving service uptake, service responsiveness, and the effectiveness of services for consumers of these population groups.

Table 1. *Characteristics of Home and Community Support Workers (HCSWs)**

Characteristic	Details	
Age	35 and under	25%
	36-50 years	35%
	51 and over	40%
Gender	Female	95%
	Male	5%
Hours worked	Average per week	21 hours
Ethnicity	Māori	12%
	Pacific	18%
	Asian	8%
	Pakeha	48%
	Other	14%
Education	No formal qualifications	61%
	Level 2	31%
	Level 3	9%
	Level 4 and above	5%
Currently studying	Towards Level 2	12%
	Towards Level 3	6%
Completed qualification within last 5 years±	Level 2	62%
	Level 3	56%

Note. *Based on the NZHHA (2011a) survey of association members. ± The number of people who had completed a qualification in the last five years divided by the number who had started.

Workforce training

Formal qualifications

Careerforce has developed qualifications that support the beginnings of a career pathway for the home and community support sector to progress to higher levels. The most relevant current qualifications on the NZQA framework related to home and community support services are:

- National Certificate in Health, Disability and Aged Support (Foundation Skills) (Level 2)
- National Certificate in Health, Disability and Aged Support (Core Competencies) (Level 3)
- National Certificate in Community Support Services (Intellectual Disability) (Level 3)
- National Certificate in Community Support Services (Human Services) (Level 3)
- National Certificate in Diversional Therapy (Level 4)
- National Certificate in Community Support Services (Disability Information Provision) (Level 4)

- National Certificate in Health, Disability and Aged Support (Senior Support) (Level 4)
- National Certificate in Disability Support Assessment, Planning and Coordination (Level 5).

According to the NZHHA (2011b), at a minimum, workers providing domestic care need to attain the level 2 (L2) foundation skills qualification. Compulsory unit standards included in the L2 qualification cover consumer rights, the role of support workers, maintaining a safe and secure environment, and applying a service plan.[7] The NZHHA has also said that for workers providing personal care to people with high support needs, level 3 (L3) qualifications are becoming increasingly necessary. The association's goal is to have 80 per cent of the workforce with a L2 qualification within five years. They are also advocating for minimum training to take place within a specific period of working (such as the first six months). The adoption of minimum training requirements will improve the consistency of similar services delivered across New Zealand and lift service quality (NZHHA, 2011b).

Other training

In addition to formally recognised national qualifications, information collected as part of the Quality and Safety project and NZHHA (2011a) survey indicate that workers in home and community support services may require training in:

- health and safety (for example, safe moving and handling)
- specialised disabilities (for example, autism, behavioural support and dementia)
- supported living and employment
- challenging behaviour
- professional boundaries
- computer literacy
- basic literacy skills.

Grant funding

To support workforce training in MoH funded home and community support services, Te Pou has been contracted since 2009 to administer grant funding. For eligible home and community support services to receive grant funding there is a primary requirement that funded trainees be employed in a role that involves significant interaction with disabled people (consumers) funded under a MoH disability support services contract.[8] The grants currently administered by Te Pou include a:

- training grant for approved national certificates and diplomas, including L2 and L3 qualifications

[7] Elective units include communication, eating and drinking, infection control, observing and reporting, report writing, continence, impact of change, infectious conditions, quality of life, response to death, restraint, safety, key comfort cares and medication.

[8] Training grant requirements were reviewed in 2012 as home and community support services frequently have multiple contracts and staff who work across different client groups. To be eligible for grant funding, trainees must work with disabled people funded under a MoH DSS contract. Currently, the number of trainees (or staff) a provider can get grant funding for is based on a formula that takes into account funded hours and total staff numbers (MoH DSS funded hours/total funded hours x the number of total staff). For further information about training grant requirements talk to a Te Pou Regional facilitator – see http://www.tepou.co.nz/supporting-workforce/DWD

- effective practice grant which supports the development of frontline support services staff and directly benefits consumers (for example, numeracy and literacy; specific disabilities; behaviour support; values and ethics; cultural responsiveness, safety and competency training; community inclusion)[9]
- leadership development grant for leaders and emerging leaders to take part in leadership development training (such as programmes that support provider development; governance; leadership and management)
- consumer leadership development grant to assist consumers (both disabled people and family/whānau) to take part in leadership development activities.

The training grant, which covers L2 and 3 training and other formal qualifications, may be used to cover costs such as staff time spent in training/backfill, course programme costs and resources.

About one-third of all training grant recipients administered by Te Pou in 2012 were either Māori or Pacific peoples (276 and 184 respectively). Interim figures available from Careerforce[10] also indicate that in 2012 about one in three trainees across all sectors they support were either Māori or Pacific (1284 and 861 respectively). These figures are in line with expectations given the proportion of Māori and Pacific peoples estimated to be working in the disability sector.

Effective workforce training

Effective workforce training is conceptualised for the purposes of this project as a systematic process that leads to positive changes in job performance and contributes to better outcomes for consumers (see Brinkerhoff, 2005; Salas et al., 2009, 2012). That is, successful training builds the capability and competency of workers, who then use the knowledge and skills gained in practice to make a difference.

A literature review was undertaken to identify key factors supporting effective workforce training. The literature indicates that what happens during training is not the only thing that matters. Key factors supporting successful training include the training content itself and its delivery, an organisation's workforce training infrastructure, and individual trainee characteristics. In other words, successful training depends on the interaction between a range of different factors (see Brinkerhoff, 2005; Salas et al., 2009; Salas, Tannenbaum, Kraiger, Smith-Jentsch, 2012). The key factors identified in the literature and summarised in Table 2 are expected to contribute to successful training outcomes for Māori, Pacific and rural workers in smaller home and community support services.

[9] Formally called open round grant. Priority areas are reviewed and advertised annually on the Te Pou website.

[10] Personal communication, 27 February 2013.

Table 2. *Critical Success Factors for Workforce Training*

Success factors	Examples
1. Assess training needs	• Organisational analysis of training priorities, resources available and potential constraints • Person analysis to identify current competency levels • Job-task analysis to identify critical work functions • Assess how training aligns with existing goals, values and safety aims
2. Organisational support	• Provide organisational support for the training initiative (for example, obtain stakeholder commitment) • Communicate the value of training to the organisation • Emphasise training in recruitment processes • Openness to improving training processes and procedures and use of knowledge and skills in practice
3. Learning climate	• Prepare supervisors and leaders with the right information to engage in discussions to build learners' motivation to undertake training • Consider how training is communicated to staff (for example, how it is framed, mandatory training policies, and training benefits) • Establish clear expectations of what the training will involve
4. Training resources	• Determine resources required and time commitment and ensure their availability (such as staff time to participate in training, cover training costs, human resources, venues etc.) • Ensure training staff have access to appropriate professional development opportunities • Document relevant policies and procedures required for training
5. Trainee motivation and confidence	• Build trainees' self-efficacy and learning motivation • Convey a belief in trainees' ability and have high expectations of trainees • Build positive relationships with trainees
6. Training content and delivery	• Use appropriate instructional principles • Ensure training content is relevant and considers trainees' needs, background and knowledge • Allow sufficient time to support learning • Develop appropriate learning materials • Use a wide range of examples and teaching methods • Provide information, demonstration and opportunities for practice and feedback • Create culturally appropriate and non-threatening learning environments
7. Technology use	• Use technology wisely • Develop a sufficient infrastructure (for example hardware, software, internet access, and technical support) • Ensure trainers have appropriate skills and knowledge

		• Support trainees to develop necessary computer skills
8.	Use of skills on the job	• Facilitate application of skills and knowledge on the job (such as providing opportunities and removing barriers to using new skills) • Provide encouragement and reinforce learning on the job • Model desired behaviour
9.	Evaluate training outcomes	• Measure training program effectiveness (for example use formal and informal data) • Use Māori and Pacific specific data to inform decisions for these population groups • Use data to develop, deliver and implement future training

Note. Adapted from Salas et al., 2009, 2012. See also Te Pou (2013).

Project aims

This project aimed to develop a better understanding of barriers and enablers to effective workforce training for home community support workers in small MoH funded home and community support services. A key focus was on identifying factors supporting the successful uptake and completion of formal L2 and L3 qualifications for Māori, Pacific and rural workers. In particular, the National Certificates in Health, Disability and Aged Support – Level 2 Foundation Skills and Level 3 Core Competencies.

Method

Sample and recruitment

Ten MoH funded home and community support services providing support to fewer than 1,000-1,500 disabled people aged under 65 were selected for interview to represent diversity on the following characteristics:

- location – focus on rural and provincial providers
- Māori and Pacific providers
- agency size – number of clients and staff
- level of uptake of training grants administered by Te Pou – high to low
- covering all national regions.

In each organisation the person selected for interview had an overarching responsibility for staff training. All participants were recruited directly by the researcher, following an initial approach by Te Pou. Depending on the size of the provider agency and its management structure, the person interviewed was most often the human resource, quality or training manager. Two of the providers chose to have both the general manager and the person(s) with staff training responsibility involved in the interview. In total 13 provider personnel were interviewed. Individual telephone interviews were also undertaken with the three Te Pou Regional facilitators and the NZHHA CEO.

Procedure

Interviews were held mid-to-late December 2012. All expect two provider interviews were conducted face-to-face at the participants' place of work. Several interviews were undertaken by telephone to meet project deadlines. Providers were sent a food hamper as a koha for their time and input.

Interviews ranged from approximately 60 to 75 minutes in length and followed a semi-structured topic guide (Appendix A). All participants either signed a consent form (Appendix B) or gave verbal consent over the phone.

Limitations of the method

Limitations of the method were as follows:

- only 10 interviews were held – not all providers were interviewed due to practical constraints
- no large providers (with more than 1,500 disability clients aged under 65) were included in the sample
- interview questions were primarily focused on HCSW development
- interview questions (see Appendix A) did not include those specifically focusing on Te Pou's 'effective practice grant', although some people commented spontaneously on this
- interviews were conducted with providers and did not include individual HCSWs or trainees.

Nonetheless, because the provider sample included a range in terms of location, contract type, funder(s), size of clientele, and Māori and Pacific agencies, the research findings may reasonably apply to similar providers in other areas.

Reporting

Terminology

For the avoidance of confusion:

- 'research participant' refers to all those who took part in the research
- 'stakeholder' refers to all stakeholder groups – providers, Te Pou personnel, other agency personnel
- 'home and community support worker' (HCSW) refers to people undertaking either home management or personal cares tasks, or both, including family carers
- 'family carers' refers to HCSWs caring solely or primarily for one or more members of their own family
- 'providers' refers to home and community support services, unless otherwise indicated
- for the purposes of comparison, 'small providers' in this report refers to those with fewer than 500 disability clients aged under 65
- references to 'small' or 'smaller' providers generally includes Māori, Pacific and rural providers. Where Māori, Pacific or rural providers are affected in unique ways it has been stated explicitly.

References to numbers of research participants representing a particular view or experience is as follows: 'some' refers to 2-4 people; 'several' refers to 5-7 people; 'many' refers to 10 or more people; larger numbers are described as a proportion of total research participants or of the stakeholder group referred to (for example, 'a majority', 'more than half').

Use of quotes

Quotes have been selected to be representative of the stakeholder group named. To avoid identifying individual research participants, most verbatim quotes are attributed to a stakeholder group (for example, 'Te Pou Regional facilitators', 'provider management') without further description. Where additional description of the speaker is added, it is to indicate that the quote is representative of the views of a particular sub-group (such as 'Pacific provider').

Analysis

Information gathered during the interviews was analysed in relation to the nine key factors identified in the literature as supporting effective workforce training. These include:

1. training needs assessment
2. organisational support
3. learning climate
4. training resources
5. trainee motivation and confidence

6. training content and delivery
7. technology use
8. use of skills on the job
9. training outcomes evaluation.

Results

1. Training needs

The literature indicates that effective workforce training is supported by an analysis of job-tasks; individual competencies; and organisational training priorities, readiness to support training, training resources and potential constraints.

Workforce development policy

Various providers (and others) reported that having a strong, documented agency philosophy and policies for quality in service provision was important for supporting implementation of L2 and L3 training. This included a clear workforce development policy based on:

- an action plan for staff training, updated at least annually
- individual development plans for each staff member and all staff scheduled into training of some kind within each year of employment
- regular training needs analysis, and pre-L2 training requirements identified and scheduled as needed (such as literacy and disability awareness training).

Whether an organisation had a comprehensive workforce development strategy appeared to be one of the main factors influencing training uptake. Smaller providers commonly lacked a comprehensive or up-to-date workforce development policy, strategy, and/or a current action plan due to capacity and/or capability factors. Recommendations to support future workforce training included the development of a 'blueprint' for HCSW training that included a 'map' or pathway for planning HCSW training, a sample workforce development strategy and plan, personalised training plan, and advice on how to budget for training within contracts, along with templates and exemplars.

Interviewees highlighted the importance of developing a workforce development funding plan that was included in the organisation's annual budget and forecasting. This included, for example:

- an allocation for training or hiring trainers
- an allocation for pay increments for staff achieving additional qualifications
- sufficient funds for training.

Priorities

The interviews primarily investigated the attainment of the National Certificates in Health, Disability and Aged Support – Level 2 Foundation Skills (L2) and Level 3 Core Competencies (L3).

Level 2

The main focus of providers was currently on facilitating as many HCSWs as possible in achieving the L2 qualification. This was in recognition that L2 training was likely to become mandatory across all funders in the near future. L2 training was seen as vital to ensuring HCSWs understood (1) the links between the services they

provided and the philosophical and policy underlying the provision of home and community support, and (2) the role and value of training and education in providing an effective and professional service.

Level 3

For the majority of providers, promoting the L3 qualification amongst their staff was seen as a 'nice to have' rather than an ultimate goal for all HCSWs. The exceptions to this were two providers whose preference was to skip the L2 qualification for all HCSWs, except those with significant literacy issues (generally family carers). Several providers commented that the L3 qualification was a suitable and achievable stepping off point for HCSWs wanting to make a professional career in the sector, and were promoting it to staff as such. These providers were advising HCSWs they would need to attain at least a L3 qualification to be considered for more senior roles and full-time work. Training to L3 was seen as essential for anyone undertaking a supervisory role.

Level 4

Some providers believed that people undertaking a supervisory, coordination or training assessor role should be trained to at least level 4 (L4).[11]

Disability awareness training

Among the recommendations made by some providers to support future workforce development was the provision of disability awareness training for HCSWs as part of their induction training (ideally within the first three months). Providers pointed out that the experience and impacts of lifelong disability differ from those associated with older age. Disability awareness training would enable staff to understand the need for and value of training for client safety, quality service delivery, and job satisfaction.

Readiness to support training

Smaller providers

The level of readiness for workforce training, particularly amongst most small providers, was affected by competing priorities. Most small providers interviewed reported struggling to meet their contractual requirements and were operating primarily in a reactive rather than proactive manner to meet day-to-day business needs. That is, their main priorities included managing client referrals; allocation of staff and rosters; staff cover and recruitment; and essential recording and reporting, including contract reporting. Building a training infrastructure and workforce development were necessarily lower priorities.

Training resources and constraints

A number of factors were associated with greater participation in training, including provider size and capacity, based on contract size and the number of staff and clients. That is, larger organisations tended to be better to able to support HCSW training. These providers may have had better access to key factors identified as enabling

[11] Relevant L4 and L5 qualifications are listed in the Background section.

training participation including training resources, training capability and capacity, dedicated training positions, and a comprehensive workforce development strategy.

Funding

Long-term lack of adequate funding and resourcing for the sector was identified by all research participants as the main barrier to training uptake. Providers typically held multiple contracts with two or more funders or contractors, such as the Accident Compensation Corporation (ACC), District Health Boards (DHBs), MoH, and larger organisations they contracted to. Contracts tended to be relatively short-term, resulting in a lack of provider income and reluctance to invest in training that had little or no short-term benefit for providers. Contracts also tended to include insufficient funding for provider training infrastructure development, such as management training, development of policy and training strategies, and training or employment of personnel with capability to take on workforce development tasks.

Underfunding has been exacerbated in the past few years by changes to funder policy around contracting. For example, ACC changes have resulted in many small providers now subcontracting to larger ones and providing the same service for a lesser amount. Reduced income levels have made it even more difficult than previously for providers to offer training, including in-house training. Some providers had even resorted to requiring HCSWs to pay for their own training (for example, first aid training).

Providers said they were constantly training new staff, including new trainers and assessors, which was unaffordable and unsustainable. Workforce turnover is high in the sector due to factors such as low pay for home and community support staff at all levels compared with other options; variable hours; lack of career opportunities and secure income. Some regions have local factors that affect staff recruitment and stability (such as seasonal work options that are significantly better paid than home and community support work).[12]

To support future workforce development, providers reported a need for funding to cover all components of training. This included funding to cover staff time spent in training and/or backfill, travel costs, graduations, and the training of trainers and assessors. If these costs are not sufficiently recognised by grant funding or in the amounts, terms and conditions of contracts, the shortfall has to be borne by the provider from their general budget. The providers interviewed pointed out that there is no contingency funding in their budgets for such expenses, which they then have to pass onto trainees.

Perception of the HCSW role

The credibility of HCSW as a profession was identified by providers as a training barrier. Providers said the HCSW role is poorly paid in terms of the skills required and this makes it difficult to build credibility as a profession. This in turn becomes a training barrier for both providers and employees. Providers recommended profiling the value of the HCSW role and work. Increasing the credibility of HCSW as a profession would also

[12] Nevertheless, the recruitment of family carers into the profession, wherever possible and appropriate, was seen as an effective way to recruit more Māori and Pacific workers into the profession and to utilise their acquired skills.

support better recognition of the importance of qualifications across the health and disability sector and encourage future training participation.

> *"It's really specialised work requiring specialised skills that most people don't have intuitively and need to be trained in, but they're paid less than most commercial cleaners, so it's no wonder some of them aren't motivated to get trained, especially if they lose income."* Māori provider

Several providers felt funders, in particular central government agencies, did not sufficiently support NZHHA as the professional association or the development of home and community support work as a profession, and that their support was essential to that development. Providers supported building HCSW as a profession within the sector, through collaboration between funders and providers and the NZHHA, for example:

- development of a scope of practice
- minimum qualifications
- career pathway/s
- wage bands and minimum pay level
- regular national and/or regional conferences.

Career pathways

The creation of educational and professional development pathways would help HCSW be considered a profession and demonstrate the role incorporates opportunities for advancement. This would require greater collaboration with tertiary educational institutions to provide advanced education and training options for HCSWs. At least one provider was liaising with a local tertiary education institution to establish ways to staircase from L2/L3 to enrolment in nursing studies and other health occupations.

2. Organisational support

The literature indicates successful workforce training requires a significant level of organisational commitment. This includes communicating the value of training to workers.

Various providers (and others) interviewed said having management and governance personnel who prioritise and actively drive workforce training and skills acquisition has helped them implement L2 and L3 training. Organisational commitment to workforce training has been demonstrated by:

- making workforce training to L2 mandatory
- having a dedicated quality or training manager position, at least part-time, and employment of a person with relevant skills, qualifications and experience in that role
- including training managers in recruitment processes
- advising new staff of mandatory training requirements and including it within employment contracts.

Conversely, a lack of management commitment or leadership for workforce training was identified as a constraint by both providers and other stakeholders interviewed. Several research participants commented that some provider managers and/or governance bodies were less than fully committed to L2 training or beyond.

They apparently did not see any significant benefit from training for their organisation. Without that commitment, staff training was not driven effectively by management. Factors that might contribute to this stance were believed to be:

- managers themselves lacking any external qualification, and not willing to undertake L2 or L3 qualifications – two of the managers interviewed fell into this category
- managers or governance bodies not recognising the value to the organisation, clients, staff and the sector at large of HCSWs and more senior staff having advanced learning and external qualifications (versus in-house training)
- a belief that in-house training was sufficient for the HCSW role
- management being primarily focused on the financial viability of the business or profit
- a management perception that high staff turnover (including family carers likely to be employed for only a short time) defeats the value of staff training to L2 or beyond – some participants commented that this attitude creates a 'self-fulfilling prophecy'.

3. Learning climate

The literature indicates that it is important to build trainees' readiness and motivation to undertake training. Providers wanted advice on ways to promote training to staff. In addition to making L2 training mandatory, strategies used by various providers to motivate workers and signal the value of training to the organisation included:

- focusing on training benefits
- building financial incentives (for example, bonuses and pay increases) into achievement of qualifications, and/or other incentives such as more hours or more interesting work
- making graduation an important event within the agency that celebrates and recognises trainees' achievements.

Mandatory training

Having mandatory training policies was one of the main strategies used to encourage training uptake. Providers and other stakeholders noted that there was now a sufficient workforce 'pool' for selective recruitment to require minimum training levels.

The majority of those interviewed believed a L2 certificate should be mandatory for all HCSWs other than family carers. Half thought that ideally it should be mandatory for *all* HCSWs within 6-9 months of taking up that employment, irrespective of the number of hours worked in that role or the type of service being provided (for example, home management or personal cares).[13]

[13] Two providers noted that many HCSWs work for more than one agency, in order to have a sufficient income; as a result, providers are often unclear how many hours a HCSW is working in that role at any given time.

Training benefits

Another main incentive used to encourage training participation was highlighting the job satisfaction and improved consumer quality of life that comes from HCSWs improving their skills. Active support from mentors and agency management had also helped trainees identify real benefits from training for their work (for example, ways to make their work tasks more meaningful or easier).

Many trainees reportedly had difficulties recognising the value of external qualification training. For example, providers commented that some HCSWs, especially those who had been in the role for a number of years, were family carers and/or were undertaking home management tasks only (that is, not personal care tasks), did not recognise the role as specialised or see any need for training. *"They just think, well, you don't need a qualification to do the vacuuming."* Moreover, one of the most common reasons for training non-completion was a loss of motivation due to trainees' being unable to see the relevance of training for their actual work. This was largely attributed to the employing agency lacking either capacity or capability to support individual trainees sufficiently through training. Consequently, communicating the value of training to staff was recommended to help motivate and encourage trainees to complete training.

Financial incentives

Few financial incentives were used to encourage HCSW training participation. In most instances achievement of L2 or L3 qualifications resulted in a meagre or no pay increase of any kind. Most providers interviewed did not recognise the achievement of qualifications with financial incentives. Nevertheless, a guaranteed worker pay increase or bonus on completion has been found to help motivate trainees to undertake and complete their training. Even minimal amounts, such as 50 per cents per hour, have helped motivate some workers. Three agencies had offered their trainees this incentive. In addition, one larger provider had found that a lump sum bonus ($200 for L2 and $300 for L3) had resulted in higher completion rates, even among trainees who had encountered significant personal barriers.

Graduation ceremonies

Graduation ceremonies and acknowledging trainees' success were strategies used to motivate workers to undertake training. Interviewees believed attendance by prospective and current trainees at graduation ceremonies helped them see the impact on those who had recently completed their training. Although, providers also said graduation ceremonies needed to truly honour the achievement of graduates. For example, the presentation of flowers and/or small gifts; wearing of gowns and caps; photos of graduands; and certificates presented by a person with relevant status (such as a DHB or MoH portfolio manager, kuia and kaumātua, Pacific church minister, Careerforce advisor, or trust board member). Some providers displayed graduation photos in a 'Wall of Fame' in a prominent place within their organisation.

4. Training resources

To support effective workforce training the literature highlights the importance of assessing and securing necessary resources. Interview findings indicate key factors influencing training uptake include access to training resources and other features of provider capability to train staff, as well as supports for providers to build capacity and capability to implement training.

Training resources

The key training resources required to support training mentioned by providers included the documentation of policies and procedures, access to training venues, support for travel costs, and training information.

Policies and procedures

For HCSWs to undertake L2 training, the employing agency first needs to have documented agency policies and procedures in areas relevant to training topics (for example, incident reporting; infection control; and informed consent). Some smaller providers frequently lacked documented policies and procedures. Recommendations to support future workforce development therefore included the provision of templates and exemplars, such as policy and procedure documents.

Training facilities

A training barrier reported by smaller providers commonly included a lack of essential training facilities, resulting in having to pay for these (such as venues and equipment). This affected the rate at which they could offer HCSWs training. Therefore recommendations to support future workforce development included the development of regional hubs that help identify and broker access to training resources, including free training venues.

Travel costs

Providers in rural and some large catchment areas reported workforce training challenges due to their geographical areas. Some providers with comparatively small contracts were providing services across very large catchments areas, due to a relatively low population density (for example, the whole of Southland and South Otago). This makes it virtually impossible for teams to meet together regularly and for providers to afford to bring staff together for training. In general HCSWs work from their home and vehicle and are rarely required to attend the provider's premises due to the mobile nature of the work. To attend training sessions, rural providers noted that some trainees needed to travel up to 120 kilometres, and many will cover 60 or more kilometres round trip. Due to current petrol prices and low pay rates, this is unaffordable for most HCSWs. Also, HCSWs in rural areas may incur a loss of income since training hours and travel are generally unpaid, and undertaking training often prevents them from earning in the same period. In addition, common pragmatic constraints for HCSWs, particularly family carers, included having to share family vehicles or having a vehicle that was not fit for sustained travel. These constraints were exacerbated where the person or people being cared for had high support needs.

Consequently providers reported a need for funding to cover travel costs.[14] Providers believed this would help motivate trainees to undertake and complete training. Three providers had paid trainees' mileage costs. Others had provided training in trainees' homes, to obviate the need for travel for them.

Training information

Providers said the current information available on training was often confusing given the number of external organisations involved. Providers wanted better information about different organisational roles; qualifications available; and potential cost saving strategies.

Organisational roles

The multiple organisations (for example, funders, Te Pou, Careerforce,[15] training providers) involved in supporting and implementing formal qualifications was experienced by smaller providers as overly complicated and confusing to access. They also experienced difficulties in figuring out who provides what (for example, the qualification, funding and training).

The distinction between the services, roles and functions of Careerforce and Te Pou respectively were not well understood by smaller providers. This was less clear since Careerforce launched the assessment support programme (or rebate system) in October 2012. Providers said that greater collaboration by Careerforce and Te Pou was needed to clarify which organisation provides what services, and how those services can be dovetailed most effectively to support future training.

Qualifications

The multiple agencies offering training in L2 and L3 qualifications was confusing and unhelpful for several providers. Some providers were unclear whether these providers were offering identical or varied qualifications. Smaller providers reported difficulties in knowing which of the myriad of qualifications available were relevant to workers at various levels, and which were most credible and valuable at different employment stages. This was a particular challenge for Māori providers, given the range of kaupapa Māori training options also available in the health and disability sector.[16] Small providers did not have time to comprehensively research various options.

Having a strong relationship with a Careerforce advisor was seen as pivotal to obtaining information from that agency. Several providers commented that they had encountered significant problems trying to get essential information from Careerforce over the past two years. Particular problems were: rapid turnover of Careerforce personnel; new staff not having the information sought by providers; delays in getting information; and a lack of clarity about who at Careerforce was responsible for what. The problems in combination had delayed training

[14] Currently, training grants administered by Te Pou do not cover travel costs for trainees. One provider had obtained funds to cover trainees' mileage costs in the past, but other providers had not (when funding for this was available).

[15] As the owner of the L2 and L3 qualifications.

[16] Māori and Pacific providers also prefer face-to-face meetings for the provision of information.

uptake significantly for some providers. Providers also wanted clarification on current qualification fees and what they covered.

Cost saving strategies

Providers were interested in information and support to enable them to better afford training. This included advice on cost saving strategies, like printing or photocopying training materials; accessing specialist agencies that provide training on particular topics; sharing training with other local providers; and free training available. Some providers had already reduced training costs by finding free trainers in relevant topics. These included organisations such as Douglas Pharmaceuticals, a local hospice, the Human Rights Commission, a community law centre, disability resource centres, and a family violence prevention service.

Human resources

Critical to the success of workforce training were a number of people in different roles. This included managers and leaders, administrative staff, trainees, trainers, assessors and mentors.

Dedicated training roles

Having a dedicated (even part-time) quality or human resource manager (rather than the role being an adjunct to the general manager role), appears to be one of the key factors influencing training participation. In addition, having someone with capacity and capability within an organisation to identify sources of funding for training and to make successful funding applications has been reported by various providers (and others) as important for implementing L2 and L3 training.

Among smaller providers, limited capacity and/or capability were common workforce training barriers and affected the rate at which they were able to offer training. This included:

- insufficient management capacity to set up training, or to develop training capability
- the level of management turnover because of the stressful nature of the role, resulting in a lack of capability to organise training
- lack of succession planning for tasks related to training (for example, assessors, training managers), which can result in long gaps between training availability.

Trainees

Paying HCSW to attend training was a challenge for providers. There was a perception that funding was largely unavailable to cover staff training or backfill. This meant employers believed they had to either pay staff to train, which very few could afford; or trainees had to undertake training with no pay. This was seen as a major disincentive for HCSWs given competing priorities. Trainees have limited availability and undertaking training usually obviates their ability to undertake paid work during that period. Therefore providers reported a need for funding to cover staff time spent in training and/or backfill and for training to be scheduled to minimise any loss of income.

Smaller providers commonly reported having insufficient staff capacity to backfill positions for HCSWs to undertake training. An inability to backfill trainee positions and staff losses were among the multiple factors which potentially resulted in delays to training schedules for smaller providers. Consequently, small providers with generally limited capacity found meeting training completion deadlines difficult.

Trainers and assessors

Providers strove where possible to have competent trainers and assessors to deliver and implement training. Providers recommended using trainers who were highly experienced both in training and in the home and community support sector. Ideally trainers would be people who had worked for at least two years as HCSWs, were well trained trainers, and had a comprehensive understanding of the sector and the locality of where training was being undertaken. Having trainers that were culturally matched to trainees was also recommended by Māori and Pacific providers to support greater training uptake.

Providers had a preference for using as assessors the trainees' coordinator or supervisor. That is, someone who was aware of the particular clients that each trainee was working with and the context of the trainee's work. They recommended assessors had at least a L4 qualification and two years full-time equivalent work experience in a HCSW role. Recommendations also included more rigorous and consistent assessment of assessors. A need for funding to cover the training of trainers and assessors was also reported.

Smaller providers commonly lacked internal trainer and assessor capability, or experienced frequent turnover of that capability. This affected their ability to provide HCSW training to L2 internally. Among smaller providers, assessors typically take on this position as an adjunct to a coordinator or supervisor role, which has to take priority. Some agencies noted that workforce turnover is also high amongst assessors, as achievement of advanced qualifications increases the likelihood of staff either being 'poached' or seeking to upgrade their status (for example by undertaking university study towards a profession). In addition, a lack of succession planning for training roles (for example, trainers, assessors and training managers), can result in long gaps between training availability.

The option of providers undertaking training internally was seen by some as counterproductive. To do so seemed attractive because it had the appearance of a lower cost option. It however became a *"millstone"* once providers encountered the complexity of training and infrastructure supports required (for example, trainers, assessors, workforce development strategies, venues and other essential resources). Therefore several research participants strongly favoured training in external qualifications being provided by external trainers, as a highly cost-effective and stress-free medium for smaller providers. Some smaller providers, acknowledging that they did not have capacity or capability to undertake L2 training internally, were keen to outsource training to specialist trainers, but did not feel confident researching the various options available or making informed decisions about which one was most appropriate. They were keen to see a brokerage service that would help them locate suitable trainers matched to their needs.

One large provider was already providing training packages for smaller providers under a contract arrangement that had been very successful. They had also supported those agencies to establish a workforce development strategy and action plan. That model was supported by smaller providers, who felt that agencies working in the industry would have a better understanding of HCSWs' and providers' training needs than would professional training agencies, even those 'specialising' in health sector training. The advantages to smaller agencies were in being able to implement high calibre training for their HCSWs and achieving good outcomes, while not having to develop trainer and assessor capability themselves when that was beyond their reasonable capacity, given staffing and funding constraints. The establishment and promotion of funder-approved trainers, as an alternative to small providers undertaking training internally, was therefore identified as one strategy that could support future workforce training.

Mentors

Mentors who keep in regular contact with trainees play a valuable role in motivating trainees to undertake and persist with their training. Proactive mentoring, where mentors initiate contact with trainees rather than waiting for them to make contact, was seen as most successful. Those staff involved in regularly motivating trainees to persist and apply their training typically included one of the following:

- the trainer or the trainee's coordinator or supervisor who kept in regular contact with trainees between training sessions and discussed the application of learning
- structured encouragement by the quality or training manager
- peer learning support or a 'buddy' learning arrangement involving either pairs of trainees or pairs comprising a trainee and a recent graduate of the qualification as a mentor.

Mentoring strategies used and recommended to support future workforce development included:

- matching mentors to individual trainees, where possible and appropriate, based on trainees' residence, educational background, work type and other relevant factors
- group mentoring sessions, potentially including mentoring by Skype
- having mentors available in the evenings to discuss learning with trainees
- use of a tuakana-teina, kaupapa Māori mentoring model, to support Māori trainees.

Grant funding

Funding is viewed as a major workforce training barrier. In addition, to funding for training, providers reported a need for funding to cover:

- staff time spent in training and/or backfill
- travel costs
- graduations
- training for trainers and assessors.

Te Pou administers workforce development grant funding on behalf of the MoH. All providers except one saw the training grant as essential in having HCSWs trained to L2 or beyond.[17] Uptake of grant funding was influenced in part by provider size and capacity, based on contract size and the number of staff and clients. That is, larger providers were most likely to have received grant funding. Some providers suggested that funding for workforce training should be included in annual contracts with their funders, rather than being accessed through a separate agency.

Providers reported a significant barrier to grant funding was the requirement that funded trainees must work a significant amount of their time with disabled people aged under 65. Problems with this criterion were that:

- most HCSWs work across client categories, and have to be available to do so in order to earn sufficient income – that is, most HCSWs are allocated to clients based on geography, not client category
- most HCSWs' caseloads vary significantly even within a three month period, due to the shifting nature of both client enrolment and worker availability (such as covering for other HCSWs' unavailability)
- some providers may have few people who meet this criterion, and thus consider it not worth applying for the funding in order to arrange a special, separate training package for those few
- providers struggled to see the point in having this criterion, given that:
    - virtually all HCSWs (except some family carers) will work with a significant number of under 65 clients over time
    - the proportion of over 65s will increase rapidly over the next 10 years, given entry of 'baby-boomers' into that age bracket
    - the training has value for *all* HCSWs.

At least one-quarter of research participants recommended changes to grant funding policies. Recommendations included removing or adjusting the eligibility criterion for MoH disability support services grants administered by Te Pou, so that those grants are more readily accessible for all providers working with that client group. This is based on the principle that all HCSWs need disability training and are likely to work with people aged under 65 at some point, and that the L2 training is beneficial to all HCSWs. This could be facilitated by ACC, also funding Te Pou under a joint MoH-ACC-DHB arrangement.

There were some misconceptions about what was covered by grant funding administered by Te Pou. This included for example, costs of trainee time/backfill, training for trainers and assessors and other non-NZQA training (such as literacy training). There was also a perception that providers were required to refund grant monies for non-completers.[18] Clearer communication by Te Pou on the areas and criteria for all available grants administered was recommended. Recommendations also included making funding sources and support to access them available, along with templates and exemplars of sample funding applications.

[17] One provider preferred to make staff pay for their own training, on the basis that (1) applying for the training grant was too cumbersome and (2) it was a commitment by staff to remaining in the job.

[18] In which case any refund would have to be found from other budget allocations, which are already tightly budgeted. Some providers commented that a level of non-completion is probably unavoidable for bona fide reasons (for example, trainees moving home to follow a spouse with a better paid job, or becoming seriously ill), and it is both inappropriate and legally impossible to recoup the funds from the trainee.

The rebate (assessment support programme) offered recently by Careerforce, which the majority of providers had heard about but not all had understood fully, was seen as a major advance in being able to afford training. In particular it does not require trainees to be working primarily with people aged under 65. While providers understood that the payment of the rebate on completion of the qualification was an incentive to complete, some commented that the funds were needed at the outset of training to pay for essential components (trainers, venues, equipment, etc.). Nonetheless they realised that the combination of the Te Pou grants and the Careerforce rebate now makes training more affordable, provided they can achieve high completion rates.

Practical external support

Insufficient supports for providers to build the necessary capacity and capability to implement training was one of the key workforce training barriers identified. While both Careerforce and Te Pou provide an advisory service to providers, neither organisation was seen by agencies interviewed as providing practical support to set up the necessary systems or resources internally for training to occur. For small providers, the lack of these systems and resources, and of a 'blueprint' for setting them up, was a key barrier to implementing training.

'Blueprint' for HCSW education and training

Providers and other stakeholders identified the need to develop a 'blueprint' for HCSW training and its implementation. This would be available and support individual providers to develop customised training arrangements that suited their unique context and needs. Participants suggested a structure that included a comprehensive training blueprint, developed in collaboration by funders (ACC, MoH, DHBs), together with peak bodies (NZHHA, NZDSN,[19] NASCA,[20] and NZFDIC[21]), Careerforce, Te Pou, and possibly some of the larger home and community support providers. The blueprint would set out:

- a 'map' or pathway for planning HCSW training
- a sample workforce development strategy and plan
- advice on how to afford training (for example, sharing training with other providers; purchasing training rather than providing it internally; free training available; and budgeting for training within contracts)
- the range of hyperlinked resources available to support training, including:
    - funding sources and support to access them
    - templates and exemplars (such as policies and procedures documents, agency or personalised training plans, training budgets, and sample funding applications)
    - free resources
    - funder-approved training providers, assessors and mentors
    - advice on ways to promote staff participation in training (for example, selective hiring).

Alongside this, there is a need for support systems to assist providers to access support and funding for training. Participants suggested a structure with the following attributes.

[19] New Zealand Disability Support Network

[20] Needs Assessment Service Co-ordination Association.

[21] New Zealand Federation of Disability Resource Centres.

- Web-based blueprint with easily downloadable components and materials.
- 0800 hotline for support.
- Facilitated by the Te Pou Regional facilitators, or a similar MoH role.
- Targeted promotion of the blueprint to all contracted and subcontracted providers of home and community support services.

It was acknowledged that a special project would need to be established to develop a 'blueprint' of this kind. However, it is likely to be cost-effective in the long run and a major time-saver for both providers and the agencies supporting them.

Training hubs

The development of a regional training support 'hub' structure was another suggestion made by several providers to support future workforce development. The 'hub' structure could provide an information, brokerage and support service to providers. In Taranaki,[22] a 'hub' has been established for home and community support providers, convened by Careerforce. Providers in the area meet monthly with representatives of funding organisations, Careerforce, Te Pou and other relevant stakeholders or invited guests. The meetings are a forum for disseminating information, discussing issues, needs and new developments, and for looking at how to support one another in practical ways, lobby, and determine solutions to other sector issues. This forum has been highly valuable for providers in finding out about resources and setting up collaborations for mutual advantage.

Providers saw such a 'hub' structure and service as incorporating the following features:

- based under either Te Pou or Careerforce auspices and coordination
- a dedicated coordinator position nationally
- key mandate to support providers to achieve targeted levels of training amongst their staff
- main functions would include:
    - recruiting and training trainers, mentors and assessors
    - recruiting larger provider agencies to 'mentor' smaller ones, including providing training
    - supporting providers in their workforce development planning
    - brokering training collaborations across providers
    - providing or brokering training resources, including free training venues
    - running national and/or regional conferences biannually[23]
    - convening monthly or bimonthly meetings of providers and other stakeholders for the sharing of information and resources, and problem-solving
    - gathering intelligence for funders on providers' challenges, needs and preferences.

[22] A collective similar to this apparently also existed in Bay of Plenty at some point previously, but has not been in operation for some time. Te Pou, Careerforce and local providers are currently discussing whether to re-establish this hub or create a new one.

[23] However, NZHHA already convene conferences for the home and community support sector.

The benefits of such a service were seen as including the following:

- improved consistency in training standards
- all trainees receiving high calibre training
- reducing stress for small providers
- regular sector conferences occurring
- training provision rationalised strategically, potentially resulting in more cost-effective training delivery
- ensuring that funder requirements are strategically targeted and met.

It was suggested that the above concept could be piloted in one region initially, engaging home and community support providers such as the Disability Resource Centre Whakatane or Nurse Maude in Canterbury.

5. Trainee motivation and confidence

The need to motivate trainees to persist and complete their training was highlighted by providers. Key issues influencing trainees' willingness to participate in and complete training identified in earlier sections of this report include the perceived value of training and HCSW role, payment of travel costs, financial incentives, and the provision of mentoring and learning support. Other key trainee motivating factors mentioned by providers included learning confidence, training timeframes, and personal constraints.

Learning confidence

All providers commented that many HCSWs are *"anxious"* or reluctant learners. That is, they did not achieve at school, may have literacy and/or numeracy limitations, are embarrassed at appearing "dumb" in front of colleagues, are scared of failing, and therefore unwilling to commit to training. To help a significant proportion of HCSWs overcome their fear of study, providers identified the need for literacy training to build learning confidence and improve literacy skills. Providers employing Pacific and other migrant HCSWs noted that often these people do not lack literacy skills in their own languages,[24] but the workbooks are in English, so English literacy training is often essential. Providers also reported finding it difficult accessing funding for literacy training.

A number of strategies were used and recommended by providers to understand trainees' strengths and build their learning confidence, including:

- an assessment of each employee's strengths and needs for knowledge and skills development, and creating a personalised professional development plan for *every* HCSW
- attendance by prospective and current trainees at the graduation ceremonies of trainees who had recently completed training, so they were able to see the impacts of graduation on those completers
- provision of introductory training in preparation for L2 training, as needed, to ensure trainees' ability to benefit optimally from further training

[24] And often these people are employed specifically for their facility in their native language, to work with clients who speak little or no English.

- assistance for *all* trainees in having a successful learning experience (prior to undertaking L2 training) that results in acquisition of a certificate (such as first aid or literacy training), to avoid stigmatising those with significant learning barriers.

Personal constraints

Providers identified a number of pragmatic constraints common to HCSWs that were key training barriers and impacted on their motivation to undertake and persist with training. In addition to travel and vehicle access difficulties, HCSWs may incur additional childcare costs to attend training and have competing family priorities (for example, Pacific trainees returning to their homeland to care for another relative or take up other responsibilities). These barriers were seen as more prevalent amongst family carers, and were exacerbated where the person or people being cared for had high support needs. Three providers also noted difficulties in accessing birth certificates for staff required for enrolment in national qualifications, for a range of reasons (cost, 'red tape', and determining the person's registered birth name).[25]

Training timeframe

Providers noted that once HCSWs took up training, most completed at both L2 and L3. However, sometimes that training took longer than was expected for national qualifications. A common reason for this was trainees encountering circumstances that got in their way of completing within the desired timeframe. Provider constraints also contributed to training (other than in-house induction for new employees) often being ad hoc, irregular and taking longer than was expected for national qualifications.[26] Smaller providers with generally limited capacity found it most difficult meeting training completion deadlines. As a result, training was potentially unsatisfying for both employers and trainees, with trainees being unable to see significant benefits from protracted training, especially where training is largely workbook-based with little face-to-face or on-site supervision or assessment. A loss of motivation due to extended training timeframes was reportedly one of the most common reasons why trainees did not complete their training. The establishment of training processes that speed up learning (such as block learning) and therefore the likelihood of early achievement and award were therefore recommended.

Non-completion

In addition to a loss of motivation due to extended training timeframes, and trainees' being unable to see the relevance of training for their actual work, common reasons for the non-completion of qualifications included one or more of the following:

- trainee quit their job, either permanently or temporarily
- family carer and the service was terminated to that client
- trainee became ill and felt unable to continue the training

[25] In particular family carers, for example, those from gang families.

[26] Constraints affecting some or all providers included (a) competing priorities and capacity and capability barriers, particularly among smaller providers, (b) travel and locality training barriers, (c) lack of organisational commitment to training, (d) lack of necessary policies and procedures in place, and (e) failure to access funding for training (for example, training grants).

- loss of motivation due to isolation and distance barriers – trainee difficulties in joining group training and unable to maintain motivation without that support.

6. Training content and delivery

Training content

In general the L2 and L3 qualifications were seen as largely appropriate in both content/coverage and size of the modules. However, several providers variously identified the issues outlined below.

- A level of duplication between L2 and L3 content – this caused some confusion for providers trying to decide which qualification was most appropriate for particular staff members, and resulted in some providers deciding to 'skip' L2 and enrol HCSWs directly into L3.
- The L2 content and presentation was experienced by some HCSWs as difficult, mainly due to the language used to explain concepts, which providers saw as too "academic".
- Two people commented that the L2 assessments did not align well with workbooks.

Issues related to the cultural relevance and appropriateness of L2 and L3 qualifications are outlined below.

- Māori, Pacific and other providers all found the language in the workbooks needed to be *"translated"* for many of their staff, and felt that many of the concepts could be presented more clearly by better use of examples.
- The majority of providers commented that the module on culture is poorly framed and *"light weight"*. Specific criticisms were that the module does not distinguish adequately amongst the various Pacific cultures and their unique interpretations of 'tapu', that the concept of 'tikanga Māori' is described simplistically and inaccurately, and that cultural concepts are *"intellectualised"* and not explained in ways that are useful to learners.

Several providers commented on the need for a stronger focus in L2 and L3 (and indeed all) training for people working in the disability sector on 'disability awareness'. That is, a thorough understanding of the impacts of life-long disability in particular on people with those disabilities, their needs in terms of choice and control in their lives, and the knowledge and skills needed by people supporting these clients. These providers believed L2 training should ideally be preceded (or commenced) with a funded module that focused specifically on disability awareness, so that all future training would be understood through that filter.

Recommendations for future HCSW training included:

- rationalising the current L2 and L3 qualifications to minimise duplication and make the L2 qualification achievable by all new HCSWs, including family carers
- improving the materials on culture, in particular (1) acknowledging the diversity across Pacific cultures and (2) describing tikanga Māori concepts accurately
- using culturally relevant examples and language when explaining key concepts
- tailoring the training content and medium/style to suit trainees' culture(s).

Training methods

A number of training delivery approaches were identified as valuable for supporting training completion. This included the use of a strengths-based approach. That is, using training methods that encourage trainee engagement by building on their existing knowledge and skills.

> *"I tell them [trainees], you already know this stuff – all you need to do now is see where this principle happens in how you do your work, and write it down in a few simple words. And they get it, and after a few of those they're hot to trot."* Māori provider

> *"We focus first on building confidence… pick up on what they already know that's particularly valuable for working with that client, like dealing with someone with a drug dependence or an anger problem or autism, and show them how specialised and valuable that skill is, so they see themselves as competent professionals rather than school dropouts."* Trainer working with family carers

The importance of believing in trainees' ability to complete their training and building trusting relationships was also highlighted.

> *"We never talk about failing – that's not a possibility that's ever mentioned, it's all about when and how they'll complete the training."* Pacific provider

Other suggestions for making training attendance easy and enjoyable included:

- making training fun, to help overcome embarrassment amongst trainees with literacy limitations
- group training sessions wherever possible to enhance opportunities for discussion and the sharing of ideas and experiences that help trainees to internalise new concepts
- building into training concrete opportunities for trainees to apply new learning within their day-to-day work.

7. Technology use

Technology was being used to support training. Interviewees said DVDs and audio-visual media were already widely used in L2 and L3 training. Most providers believed that online learning was the next logical step and a way of making training more easily available and affordable for agencies and trainees, so that staff could undertake at least some training from home.[27] However, they also identified the following barriers to wide use of online training:

- amongst rural, Māori and Pacific HCSWs, both computer access/affordability and computer literacy amongst the HCSW demographic (over 40, English second language, limited schooling, lower income) were very limited; even where a family owned a computer, school students typically had priority access to it for their study

[27] There are excellent models for e-learning and distance learning available in the New Zealand tertiary education sector.

- both initial and on-going costs to agencies of buying and updating both hardware and software, and training staff to become computer literate
- technophobia amongst staff
- poor broadband access in rural areas.

Addressing these barriers is likely to be expensive. However, if these barriers could be overcome, then e-learning was seen as an ideal medium for training rural HCSWs. Some participants suggested that the social networking media might have a role in training, and at least one agency was already using Skype for trainee mentoring.

8. Use of skills on the job

The literature suggests providers need to ensure trainees have real opportunities to practise their newly acquired knowledge and skills for there to be positive changes in services that benefit consumers. The majority of providers believed the most effective way of promoting the use of learning within HCSWs' everyday work was through:

- providing the training in real work contexts, with actual clients
- mentoring during training, so that trainees learn to make connections between the theory and their everyday practice
- ensuring service coordinators and supervisors actively remind HCSWs on an on-going basis of the philosophies and policies underlying their day-to-day tasks.

9. Evaluate training outcomes

Information can be used to review and monitor training program success. While this was not specifically examined in provider interviews, they did recommend trainee assessments be based more on hands-on observations. In addition, they claimed the L2 training had had the following benefits to-date for HCSWs, services and consumers:

- raised expectations amongst clients that HCSWs will have an external qualification beyond in-house training
- more HCSWs coming to see themselves as professionals and undertaking their role more consciously and diligently
- more HCSWs understanding the value of life-long learning and becoming interested in developing their HCSW work into a career
- increased incident reporting, resulting in greater client safety
- significantly improved services to consumers.

However, interviewees said they were unclear whether there was any system or structure currently in place for evaluating the effectiveness of HCSW training in terms of its suitability in a changing service provision context.

Discussion

This research aimed to identify factors supporting successful workforce training in smaller home and community support services funded by the MoH, especially for Māori, Pacific and rural workers. The primary focus was on HCSW participation in and completion of formal qualifications. In particular, the National Certificates in Health, Disability and Aged Support – Level 2 Foundation Skills (L2) and Level 3 Core Competencies (L3).

Summary research findings

Findings indicate that effective workforce training, which leads to positive changes in service delivery and improved consumer outcomes, depends largely on having the following three aspects well addressed: relevant training content and its delivery; a sustainable and well embedded training infrastructure; and the level of learning motivation and confidence amongst trainees. For small providers (supporting less than 500 disability clients), the development of a training infrastructure was a key challenge. Trainee motivation was an issue in rural areas due to the distance workers needed to travel to attend training, and the potential travel costs and unpaid time.[28] Issues for Māori and Pacific providers were generally the same as those for small and rural providers. However, improvements to training materials and training delivery were recommended to support better outcomes for Māori and Pacific learners.

Training

In line with an earlier review of workplace based training (Ryan, 2009), a strong desire for quality service delivery that was outlined in agency philosophies and policies was identified as important for the implementation of L2 and L3 training. The majority of providers interviewed were focusing on getting HCSWs trained to L2. Many HCSWs lack formal qualifications[29] and there was an expectation that L2 training will become mandatory across all funders in the near future. L3 training was seen as a more distant goal that was beneficial rather than essential for HCSWs. In general the L2 and L3 qualifications were seen as largely appropriate in both content/coverage and the size of modules.[30] Opportunities for non-NZQA training (such as first aid, literacy and disability awareness training) were also identified as important for HCSW skill development and in encouraging workers to undertake formal training.

All providers except one saw the funding available for disability support services' workforce training[31] as essential for having HCSWs trained to L2 or beyond. Careerforce's rebate system is also enabling providers to

[28] Some regions also had local factors affecting staff recruitment and stability, such as seasonal work options that are significantly better paid than HCSWs.
[29] A survey of NZHHA members in 2011 found 61 per cent of HCSW had no formal qualifications.
[30] Health and disability qualifications (including L2 and L3 training) are being reviewed as part of NZQA's mandatory review process in 2013. Individual qualifications are reviewed to ensure they remain useful, relevant and fit for purpose, and are also reviewed within a broader context of industry or sector or social need. See http://www.nzqa.govt.nz/qualifications-standards/quals-development/mandatory-reviews-of-qualifications-at-levels-1-6/
[31] MoH grant funding administered by Te Pou.

better afford training. In addition to the training costs already covered by MoH funding,[32] providers reported a need for funding to include other indirect training costs, such as travel and graduation ceremonies to celebrate training success.[33] To improve training uptake, all research participants underlined the importance and need for adequate long-term funding and resourcing to effectively support workforce training by the sector.

Infrastructure

Effective workforce training is supported by providers having a sufficient workforce training infrastructure that includes a comprehensive workforce development strategy, strong leadership commitment towards training, capacity and capability to provide training (for example, trainers, assessors and mentors), and access to necessary training resources (such as training venues and documented policies and procedures). Better outcomes are also achieved when organisations have dedicated quality or human resource manager positions (rather than these being adjunct to a general manager role).[34]

The ability of small providers to offer training is influenced by their capacity and capability (for example, management capacity and turnover, staff available to backfill trainee positions, access to trainers and assessors, and succession planning). Small providers require more support to develop workforce development policies and action plans; to understand the roles and services of different organisations, trainer options and qualifications available; and may lack required training resources (such as training venues and documented policies and procedures). The training infrastructure available in small services impacts on their ability to support trainees to successfully complete formal qualifications within expected timeframes.

E-learning was identified as an ideal medium for rural HCSW training. However, e-learning requires a supporting infrastructure (such as computer access, hardware, software, broadband access, computer literacy, and trained staff). This infrastructure is not widely available at present and is likely to be expensive to develop. Nevertheless, if these barriers could be overcome, most providers believed it was the next logical step and a way of making training more easily available and affordable for providers and HCSWs.

Trainees

HCSWs have been described as anxious or reluctant to undertake workforce training due to previous learning experiences. Many HCSWs need support to build their learning confidence and overcome study fears. Learning motivation is also influenced by the perceived value of training; financial incentives and travel costs; the length of time it takes to complete training; the provision of mentoring and learning support; and personal constraints.

[32] This includes staff time spent in training and/or backfill (through the training grant) and some training of trainers and assessors (through the leadership development grant).

[33] These costs may not be necessarily covered by other contracts or funding.

[34] Workforce development was a lower priority among smaller providers who were focused on meeting their day-to-day business needs.

Recommendations

Funding policies need to be reviewed to improve access to workforce training for all HCSWs. Most home and community support services have multiple funders[35] and employ HCSWs delivering services to a range of clients (for example, accident and injury, older people aged over 65, and disabled people). It is rare for services to specialise in providing home and community support to disabled people aged under 65. Therefore, while MoH grant funding is available to assist the development of HCSWs who have a significant interaction with disabled people, this may only support a small proportion of the overall workforce in gaining the knowledge and skills they need to deliver quality services.[36] For minimum levels of workforce training to be implemented and achieved across the home and community support sector adequate resources need to be available. Providers wanted funding for workforce training to be more readily accessible for all HCSWs. They also called for a special training grant funding formula to be available for rural providers to cover reasonable travel costs for trainees. The MoH should therefore take a lead in all funders reviewing their funding policies to ensure sufficient funding is consistently available for workforce training across the sector.

The sector requires more information about what qualifications are available and appropriate for workers at different levels. Many small providers do not have resources available to adequately research various options. For Māori providers this is even more challenging given the range of kaupapa Māori training options also available. Small providers are also interested in identifying larger providers who are able to provide external training packages. This was seen by some as a more cost-effective and stress free medium for workforce training. Providers suggested that Te Pou provide greater assistance to agencies in determining what training would meet their particular needs and in brokering training collaborations and/or mentoring amongst providers. Therefore, information collected on training outcomes by Te Pou should be disseminated in an easily accessible way so that different services can identify useful training options. Te Pou should also update and continue to promote the disability training directory as this includes listings of different types of training and external trainers and assessors available. Regional training hubs that provide information, brokerage and support services to providers were also seen as beneficial.

Better information needs to be available, particularly for small providers, on the roles of different organisations and resources available to support workforce training. Providers also identified the need for closer collaboration between Te Pou and Careerforce, so the information and support provided to agencies was consistent and dovetailed between the two organisations. A resource should therefore be developed for the sector which maps out the key organisations, their roles and how they relate to each other. This should include links to relevant workforce development funding options, tools and resources, and be hosted by a central organisation (such as the NZHHA or MoH). Organisations involved in supporting and facilitating workforce training for the sector also need to make up-to-date information clearly available on their websites to support this.

[35] Such as Accident Compensation Corporation (ACC), district health boards (DHBs) and the MoH, and may be contracted to larger home and community support services.

[36] The NZHHA (2011) claims that about 110,000 New Zealanders receive home support for some time each year, including 10,500 people receiving MoH funded disability services, 23,000 ACC clients. In addition, about 25,000 elderly people are visited each *day*.

The sector needs better information about MoH grant funding administered by Te Pou due to misperceptions about eligibility criteria and costs covered by funding. Grant funding eligibility criteria was reviewed in 2012 to make it more readily accessible to home and community support services. The number of staff a MoH funded home and community support service can now get funding for is based on the number of contracted hours and total number of staff. The training grant can be used to cover staff time spent in training and/or backfill. While the training grant no longer covers trainees' travel costs, when trainees do not complete their training for bona fide reasons and are not replaced, providers are not required to refund grant monies.[37] In addition, other grants administered by Te Pou can be used for non-NZQA training and leadership development.[38] Te Pou therefore needs to ensure information about grant funding is clearly communicated to the sector and the mechanisms used for disseminating information are reviewed, including the Te Pou website.[39]

The sector requires practical workforce training and development support, particularly smaller services. Funding alone does not support successful workforce training; it also requires a sustainable workforce training infrastructure. Providers recommended an expansion of Te Pou's role beyond the administration of grant funding to assist agencies with workforce development planning. This includes assisting providers with workforce development strategies and HCSW training needs assessments. In addition, some useful tools identified by providers included a 'map' or pathway for planning HCSW training; a sample workforce development strategy and plan; and templates or exemplars of personalised training plans and training budgets. Providers also wanted advice on how to afford training (for example, sharing training with other providers, external training options, and free training available) and ways of promoting training uptake to staff. Ideally this would be part of a 'blueprint' for HCSW training.

Providers supported building HCSW as a profession within the sector. The development of career pathways for HCSWs will help build the role as a profession and support better recognition of the importance of formal training. NZHHA in collaboration with key stakeholders should therefore continue to explore education and professional development pathways for HCSWs. Alignment with other career pathways should also be explored. The development of career pathways with minimum pay levels will have financial implications for providers. Given HCSWs are a low paid workforce, the MoH and other funders should therefore improve remuneration for HCSWs over the longer-term. This will help demonstrate the value of home and community support work and reduce workforce turnover and providers' reluctance to invest in workforce training.

Providers need to create training structures and systems to motivate trainees to undertake and complete training. Mandatory training policies were a key strategy used for encouraging training uptake (such as L2 training completed within the first year of employment and including this within employment contracts). Other strategies include communicating training benefits; offering financial incentives (for example, pay increases or lump sum bonuses); and encouraging attendance at ceremonies for recent training graduates. In addition,

[37] As it is expected these have been already spent on training arrangements.

[38] For example, training in disability awareness and literacy training is available under the 'effective practice grant', and the 'leadership development grant' may be used to support the development of trainers and assessors.

[39] The value of face-to-face contact for Māori providers was highlighted in interviews. Suggested improvements also included a FAQ (frequently asked questions) page on the Te Pou funding applications website and that the Te Pou website be simplified and duplication removed.

payment for trainees' time and travel costs may increase training uptake, particularly in rural areas. The scheduling of training to minimise HCSW loss of income may also be beneficial. Prior to participation in formal training, trainees' confidence may be improved by undertaking short courses that lead to positive learning experiences (such as first aid and literacy training). To support the successful completion of training, providers also need to have high expectations, believe in their trainees' ability to undertake training,[40] and provide mentoring and learning support.[41] Organisations therefore need to demonstrate their support for training and create a positive learning environment.

Professional development opportunities need to be available for trainers and assessors. Providers recommended using well trained trainers and assessors (for example, assessors with a L4 qualification) with relevant sector experience. A review of workplace based training (Ryan, 2009) found some organisations employed tutors with qualifications in adult education or literacy and numeracy. Adult education training assists an awareness of different learning theories, learning styles and the need to adapt training to individual needs. A number of strategies for making training easy and enjoyable for trainees were also identified in this research and included the use of group training and mentoring sessions; making training fun to avoid embarrassment for trainees with literacy limitations; and creating concrete opportunities for trainees to apply their learning. Māori and Pacific providers also highlighted the importance of using a strengths-based training approach that builds on trainees' existing knowledge and skills, building trusting relationships, and the tailoring of training content and medium/style to suit trainees' culture(s).[42] In addition, the literature (see for example, Greenhalgh et al., 2011; Fiso & Huthnance, 2012; Hill & Hawk, 1998) and Māori and Pacific providers indicated that having tutors with the same cultural background as trainees and/or a good cultural understanding supports better outcomes. Furthermore, the use of a tuakana-teina kaupapa mentoring approach appears to be beneficial for Māori trainees. Trainers and assessors therefore need the right knowledge and skills to support effective workforce training. Some funding for the professional development of trainers and assessors is available under the 'leadership development grant' administered by Te Pou and should be promoted to the sector to support this.

Training content needs to be meaningful and include examples and exercises relevant to the day-to-day tasks undertaken by trainees. Culturally responsive training also bases learning on contexts that are relevant for trainees and incorporates different cultural understandings and learners' experiences. Moreover, research shows that Māori students are more likely to achieve when they see themselves within training curriculum (Gorinski & Shortland-Nuku, 2006). Māori and Pacific providers interviewed suggested improving training materials to include more culturally relevant examples and language, better explanations of 'culture' and tikanga Māori, and clarification of the diversity of Pasifika cultures. Providers also believed the language used to explain concepts in L2 training was too *"academic"*, that concepts could be more clearly presented, and that there was a level of duplication between L2 and L3 training content. Careerforce should therefore review L2 and L3 training materials.

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[40] Conversely, deficit thinking is where there is a low expectation of learners and training failure is attributed to trainees. This view limits progress and contributes to negative relations and interactions (Sheriff, 2010).

[41] The matching of mentors to individual trainees, where possible and appropriate, based on trainees residence, educational background, work type and other relevant factors was also recommended.

[42] The literature also highlights the importance of building relationships, culturally appropriate and non-threatening learning environments,[42] opportunities for face-to-face contact, discussion and interaction in supporting Maori and Pacific learners' success (see for example, Tomoana, 2012; Macfarlane et al., 2007; Gorinski & Shortland-Nuku, 2006; McMurchy-Pilkington, 2009; Thompson, McDonald, Talakai, Taumoepeau & Te Ava, n.d.).

In summary, key recommendations made to support future participation in and completion of formal qualifications by Māori, Pacific and rural HCSWs in small MoH funded home and community support services include:

- **Ministry of Health**
    - working with other relevant funders of home and community support services to develop integrated contracting policies so that HCSWs employed by organisations in multiple services/roles can better access training to address their workforce development needs
    - continuing to prioritise the uptake of formal qualifications for the Maori, Pacific and rural workforces in home and community support services in the updated disability workforce action plan
    - working jointly with other government agencies to explore ways of incentivising workforce training for HCSWs
- **Careerforce** reviewing L2 and L3 training materials to reduce duplication and to include less academic and more culturally relevant examples of 'culture and *tikanga* Māori' and Pacific cultures
- **New Zealand Home Health Association** taking the lead in:
    - collaborating with key stakeholders to develop career pathways for HCSWs and build HCSW as a profession
    - hosting a resource which maps out key organisations and resources available to support workforce training
- **Te Pou** taking the lead in:
    - disseminating information on training outcomes in an easily accessible way
    - updating and promoting the disability training directory to providers
    - clarifying the criteria, application requirements and timeframes for all grants administered
    - providing more hands-on workforce planning and development support to providers
    - promoting the leadership development grant as a means of up-skilling trainers and assessors
- **MoH funded home and community support services** creating positive learning environments and demonstrating their commitment to workforce training.

Appendix A: Interview guide

Research objectives

- Workforce training issues for the Māori, Pacific and rural workforces
- Appropriate and cost-effective training delivery methods
- Factors that help motivate and support training completion
- Effective workforce training infrastructures

Introduction

- Clarify purposes of the research and the interview
- Confidentiality provisions
- Independence of the interviewer
- Intended uses of data and feedback to research participants

Role

- Respondent role within the organisation; training coordination responsibilities?
- How well resourced is that role?

Agency

- What range of services does your organisation provide?
- Is the organisation currently a member of NZHHA? Has it ever been?
- Agency delivery and personnel structures
- General workforce attributes – age, sex, ethnicity, educational background, professional qualifications, average duration of current employment, other relevant characteristics
- Client demographics
- Organisation's policy re staff qualifications and training
    - What base qualifications required for employment, if any?
    - How do they communicate that training matters?
    - Is training mandatory? What are the organisation's training goals?
- What kind of training do support workers (HCSWs) get for the role?
    - Induction
    - Mentoring and support
    - On the job training?
    - Qual-based training? What kind/s?
- In general, how much do your staff value formal qualifications? Why? Why not?
- What value does the agency put on having staff trained?

- In what ways is achievement of formal qualifications supported by the organisation (e.g., fees paid or subsidised; paid time off work for study; other?)
- What other incentives are there for staff to take up training?
- What proportion of your current workforce have an external qualification relevant to the role?

Barriers to workers taking up training

- What factors get in the way of people taking up formal training, or completing it? (*Spontaneous answers first*)
- **Probe:**
    - The role structure (e.g., shifts; part-time; short-term)
    - Perception of the role
    - Worker attributes (e.g., ethnicity; first language; motivation; age; residential stability; other)
    - Lack of models
    - Costs
    - Distance
    - Agency support
    - Confidence
    - Literacy
    - Peer support
    - Calibre of the trainer/s or training
    - Tutor support
    - Features of the qualifications e.g., duration; level; delivery; cultural relevance; language
    - No $ benefit
    - No career benefit or portability
    - The current funding model
    - Other??
    - Which of the barriers that you have identified are the most important?

Enablers

- What has your organisation done so far to help address the barriers to training uptake *and* completion? How successful have those strategies been? What has been most successful? (*Examples*)
- What kinds of things do you do to prepare your workforce for training? What do you do to support your workforce to take part in training?
- How do you support trainees to use knowledge and skills gained from training in their job?
- Thinking about each of the barriers you've identified, what changes might help to overcome them?
- Thinking about the staff in your organisation who have taken up the training, what factors that have facilitated that uptake?
- What are the factors that facilitate people completing the training? What facilitates going on the next level?

- Does your agency currently take up the MOH/DSS training grants? Other MOH/other govt workforce grants or supports? Have you ever?

Improving uptake

- What gets in the way of the agency taking up training grants?
- What needs to change for more people to take up the training?
- Are there any ways in which Te Pou could support that?
- Are they aware of Te Pou's training grants?

Other comments

- Are there any other comments that you'd like to make?

Additional questions

The following questions were added as interviews progressed.

- What proportion of their workers are Māori? Pasifika? Does this vary depending on the local population?
- Why are Māori under-represented in the workforce?
- Do they want to recruit additional Māori workers? What is the best way to do that?
- Are there any barriers to recruiting support workers? If so, how are they addressed?
- Are they aware of all of the funding options (e.g., open round training grants)?
- How well informed are they about training funding?
- Are the grant conditions appropriate to their needs?
- How useful are the Te Pou regional facilitators?
- How adequate is their training infrastructure? What administrative and management supports do they have in place to support HCSW training? How is that infrastructure funded?

Appendix B: Consent form

Research on Home Support Training Access
Participant consent form

Te Pou has contracted independent researcher Pam Oliver to undertake a series of interviews with services delivering home and community disability support services. The project aims to provide information on ways in which training uptake and completion can be supported, especially for the Māori, Pasifika and rural workforces. The research will be used to make improvements to training access where needed.

Protections for people taking part in the research are:

- taking part in the research is totally voluntarily
- you can withdraw at any time without giving a reason
- you can choose not to answer particular questions if you wish
- the information you give will remain confidential and not be identified to others
- your name will not be identified in the research report
- your decision to take part will not in any way affect your relationship with or your access to services from Te Pou.

Participant consent

I have been informed about what will happen with the information I give, and I understand that it will only be used for the purposes explained to me.

I agree to take part in the interview, on the terms set out above. I understand that I can withdraw my permission at any time.

Name: _____

Signature: _____

Date: _____

Researcher's signature: _____

Many thanks for agreeing to help with the research.

Appendix C: Feedback on Te Pou's administration of grant funding

All providers except one saw the training grant administered by Te Pou as essential for having HCSWs trained to L2 or beyond. The availability of funding from Te Pou for L2 and L3 training had, for many providers, constituted the *only* means by which they could afford to train their HCSWs to L2 and L3. While the grants do not cover all of the costs to providers of arranging and implementing training, if sufficient numbers of trainees are being funded, the grants generally provide adequate funds to cover registration fees and workbooks, pay either internal or external trainers and assessors, koha venues and undertake the administrative arrangements (which are considerable for scheduling alone).

Regional facilitators

The service by Te Pou was generally seen as effective, efficient and largely satisfactory. In particular providers valued both the regional facilitator role and the flexibility with which the grant criteria were applied. Te Pou's regional facilitators were appreciated by providers for the support they provided. Specifically providers valued:

- proactive provision of information by the regional facilitators to providers about the availability of grants and the areas of training for which they were available
- regular email reminders from the regional facilitators to help them meet deadlines (such as those for grant applications or reporting on grants)
- attendance by the regional facilitators at regional meetings to provide information about grants
- face-to-face contact with the regional facilitators.

> *"I like it that she's in my face, sending me reminders that are really helpful, and letting me know about what's available without me having to go fishing to find out all the time. Who's got time for that?!"* Rural Māori provider

However not all providers received regular contact from the regional facilitators, in part because of the large areas that each facilitator covers. One regional facilitator noted the information available on agencies with disability support contracts, and the type of funding they receive is not entirely reliable.

Grant funding information

Te Pou's website was seen by several providers as confusing and difficult to negotiate, with repetition on the one hand and a lack of the information sought on the other.

> *"It seems to repeat itself but then you can't find the information that you actually need, like what expenses are covered by the grants."*

Recommendations included:

- a FAQ (frequently asked questions) page on the Te Pou funding applications website
- simplifying the Te Pou website and removing duplication
- closer collaboration between Te Pou and Careerforce, so that the information and support provided to agencies is consistent and dovetailed between the two organisations.

Grant funding criteria

Providers identified several factors that impeded their ability to provide training to staff, as outlined below.

- A significant barrier to the Te Pou funding is the requirement that funded trainees must work a significant amount of their time with disabled people aged under 65. Problems with this criterion were that:
    - most HCSWs work across client categories, and have to be available to do so in order to earn sufficient income – that is, most HCSWs are allocated to clients based on geography, not client category
    - most HCSWs' caseloads vary significantly even within a three month period, due to the shifting nature of both client enrolment and worker availability (such as covering for other HCSWs' unavailability)
    - some providers may have few people who meet this criterion, and thus consider it not worth applying for the funding in order to arrange a special, separate training package for those few
    - providers struggled to see the point in having this criterion, given that:
        - virtually all HCSWs (except some family carers) will work with a significant number of under 65 clients over time
        - the proportion of over 65s will increase rapidly over the next 10 years, given entry of 'baby-boomers' into that age bracket
        - the training has value for *all* HCSWs.

Recommendations included removing or adjusting the eligibility criterion for MoH disability support services grants administered by Te Pou, so grants are more readily accessible for all providers working with that client group. This is based on the principle that all HCSWs need disability training and are likely to work with people aged under 65 at some point, and that the L2 training is beneficial to all HCSWs. This could be facilitated by ACC, also funding Te Pou under a joint MoH-ACC-DHB arrangement.

Application process

Te Pou's online application process was a barrier to applying for some providers with limited internet literacy and experience, who found the process unnecessarily complicated and were reluctant to ask for assistance.

> *"I just gave up and sent something in on paper in the end, but I felt stupid… I probably wasted a good hour. They need to make it much simpler."*

One of the providers interviewed preferred to make staff pay for their own training, on the basis that (1) applying for the training grants was too cumbersome, and (2) it was a commitment by staff to remaining in the job.

Recommendations included clarifying that training grant funding is available for individual applicants, and not just to groups of trainees, so that new employees can commence training early, rather than waiting until there are several others ready to train. Also, clarifying the criteria, application requirements and timeframes for all grants administered by Te Pou for this sector.

Costs covered by training grant

There is a widespread perception that training grants do not cover payment of staff for time spent in training. As a result, employers believe they need to pay staff to train, which very few could afford; or that trainees need to undertake training with no pay, which is a major disincentive given competing priorities and the need to earn sufficient income. Other actual cost items that providers believed were not covered specifically by grant funding administered by Te Pou included backfill, and the training of trainers and assessors.

While training grants no longer cover travel costs for trainees,[43] providers noted that some trainees in rural areas have to travel up to 120 kilometres round trip to attend training sessions, and many will cover 60 or more kilometres. At current petrol costs, this is not affordable for most HCSWs, given low pay rates. Recommendations therefore included the creation of a special training funding formula for rural providers to cover reasonable travel costs for trainees.

Grant funding administration

Providers appreciated the flexibility with which Te Pou implemented the funding conditions, in particular that Te Pou had: agreed for one provider to cover trainees' mileage costs;[44] not been 'bureaucratic", but had accepted providers' guarantee that trainees were working primarily with people aged under 65; provided a *"friendly face"* in monitoring grant compliance and reporting.

Providers appreciated the prompt grant payments by Te Pou on meeting milestones, so providers did not have to bear a financial deficit pending receipt of the grant monies. Providers were unwilling to take out a loan or use overdraft facilities for any reason in the current contracting environment. Some felt that it was not feasible for them to confirm actual training arrangements until payment had been received from Te Pou, for fear of financial embarrassment.

[43] One provider had obtained funds to cover trainees' mileage costs in the past, but other providers had not.

[44] A 25 per cent special circumstances allowance has been available in the past and has been used to cover travel and accommodation.

Refund unused grant monies

There is a perception that providers are required to refund grant monies for non-completers even though funds have already been spent on training arrangements (rather than on individual trainees). In which case, any refund would have to be found from other budget allocations, which are already tightly budgeted.

Some providers commented that a level of non-completion is probably unavoidable for bona fide reasons (for example, trainees moving home to follow a spouse with a better paid job, or becoming seriously ill), and it is both inappropriate and legally impossible to recoup funds from trainees.

Recommendations included adjusting or confirming for providers the funding terms and conditions. For example, the expected timeframes for training completion and whether there is a need to refund monies for trainees who do not complete.

Other grant funding available

Providers reported challenges in accessing funding for literacy training, and for the training of trainers and assessors. Literacy training is needed by a significant proportion of HCSWs not only to improve their literacy skills but to also build learning confidence to overcome their study fears. Recommendations therefore included clarifying that funding administered by Te Pou is available for non-NZQA training (including literacy training) and for building staff training capacity.

Providers saw the benefit in trainees undertaking short courses to increase their learning motivation and confidence. It was recommended that funding for first aid, literacy and disability awareness training continue, since it is not only essential for the majority of new HCSWs, but has an additional value in introducing HCSWs to the value and achievability of further professional training.

Workforce development support

To support workforce training and development in smaller home and community support services it was recommended that Te Pou's role be expanded beyond the administration of grant funding to also include support to agencies with workforce development planning, for example, assisting providers with:

- the development of workforce development strategies
- HCSW training needs assessments
- determining training 'packages' to meet providers' particular needs
- brokering training collaborations and/or mentoring amongst providers.

It was acknowledged that expanding the regional facilitator role would require additional capacity and capability and changes to Te Pou's contracted functions.

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