Future Skills and Training Needs Scan

Key Results

June 2009

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1 EXECUTIVE SUMMARY

Careerforce's inaugural Future Skills and Training Needs Scan sought answers to a variety of questions about New Zealand's health and disability workforce, covering areas such as demand for services, role and skill shortages, and training needs and barriers.

A key finding from the Scan is that the demand for health and disability services is increasing. Major reasons identified for this increased demand include public policies such as Ageing in Place, changing service delivery models and associated compliance requirements, and demographic and economic changes.

Organisations are responding to this increased demand in a number of ways, including greater investment in workforce development and training, working differently, and enhancing their capacity to deliver health and disability support services.

When asked about current and emerging shortages, respondents repeatedly identified two roles as critical in filling the gaps, namely: care and support workers, and Registered Nurses (selected by 55% and 23% of respondents respectively). For both of these roles, lack of funding was cited as the major barrier to overcoming shortages.

For care and support workers, increased pay and improved conditions was the solution suggested by 33% of respondents who cited shortages for this particular role.

Three key skill groupings emerged as critical for care and support workers:

- Communication and interpersonal skills (representing 27% of the critical skills identified);
- Team leader/supervision/management skills (22%);
- Discipline specific skills (20%).

Providing care and support workers with a range of accessible and supported training options, and developing career pathways that allowed them to follow a variety of specialty topic areas were identified as key training and development needs for the future.

The key training and skill development needs identified for Registered Nurses included focusing on developing leadership, supervision and management skills, and providing postgraduate studies in areas of specialisation such as the recovery model.

The most significant barrier to achieving a sustainable and skilled care and support workforce is funding. Respondents identified that funders need to resource health and disability service providers to an adequate level so they can attract staff, offer training, and provide incentives towards the acquisition of qualifications. Other barriers included language and literacy issues, difficulties in motivating workers to commit to training, lack of incentives, and issues surrounding the retention of staff once they are trained.

Priorities for Careerforce include better supporting the assessment process and extending the career pathways available by accelerating the development and registration of national qualifications.

2 INTRODUCTION

This report provides the key findings from Careerforce's inaugural Future Skills and Training Needs Scan, which was undertaken between March and May 2009.

This Scan sought answers to a variety of questions about New Zealand's health and disability workforce, including demand for services, role and skill shortages, and training needs and barriers. The aim of the Scan was to help Careerforce gain a better understanding of the pressures experienced by the workforce, identify current skill and training gaps, and understand how these gaps are expected to change in the future.

Although the health and disability workforce is larger than the workforce for which Careerforce currently facilitates training, it was considered important to make the Scan as wide ranging as possible, as changes in any workforce group can impact on the care and support workforce.[1]

The Scan was launched on 3 March 2009 and closed two months later on 5 May 2009. During this time period the extent of New Zealand's deteriorating economic situation had yet to be fully realised. The Scan also took place against the backdrop of the election of a new National-led Government (elected in November 2008).

Careerforce's future qualification development will be informed by the Scan's findings, as well as by the engagement, consultation and research activities undertaken as part of Careerforce's legislated leadership role.

Findings will also inform the development of Careerforce's Strategic Training Plan and Investment Plan. These two documents are required by the Tertiary Education Commission to inform Industry Training Organisation funding decisions.

[1] For a definition of the care and support workforce, see Appendix.

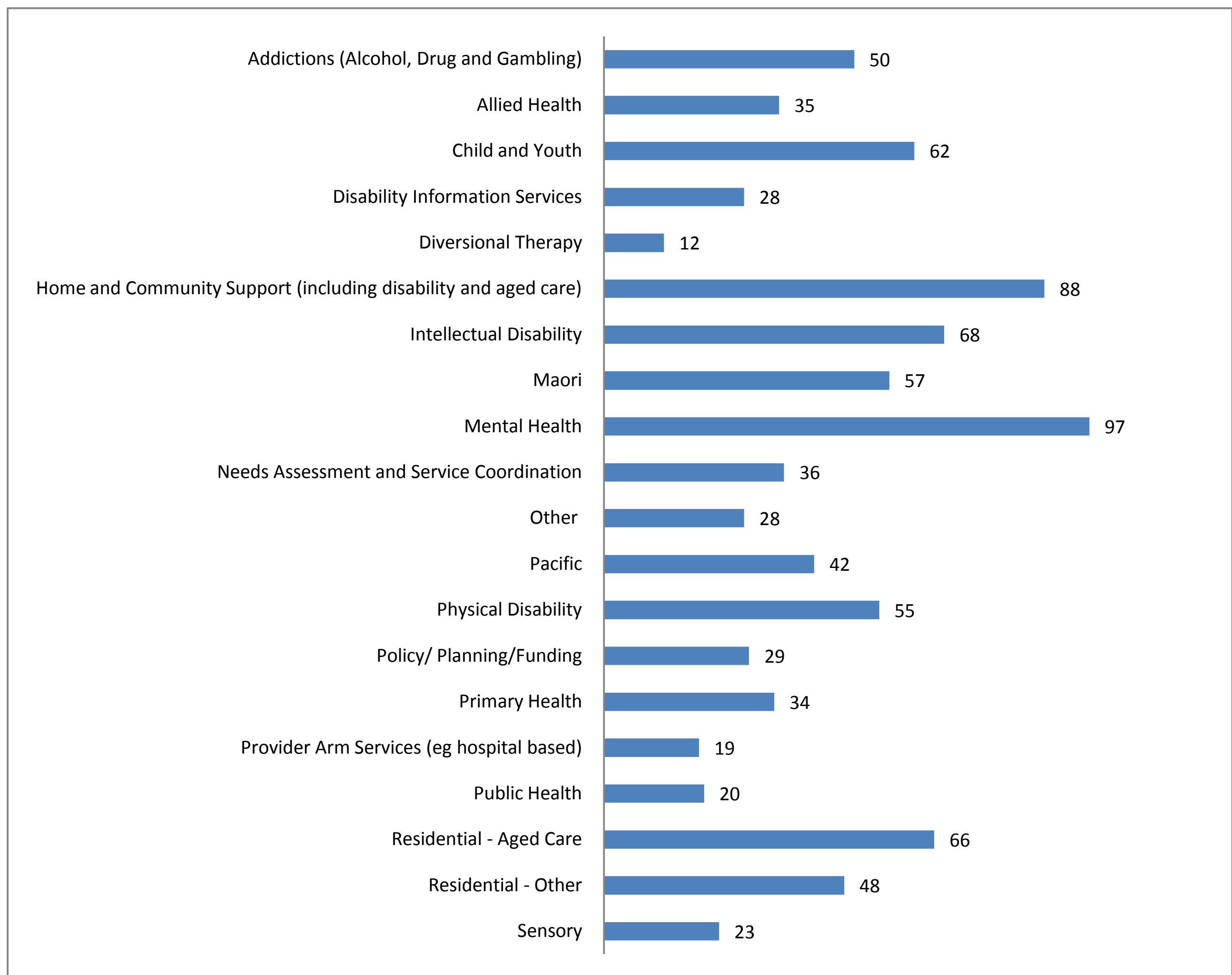
3 SCAN PARTICIPANTS

Over 200 people responded to the survey. Respondents covered every District Health Board (DHB) region and came from a wide range of sectors and organisations.

3.1 SECTOR REPRESENTATION

The largest sub-sector represented was mental health, followed by home and community support (including disability and aged care). Chart 1 below lists the sub-sectors represented by respondents.[2]

Chart 1: Sub-Sectors Represented

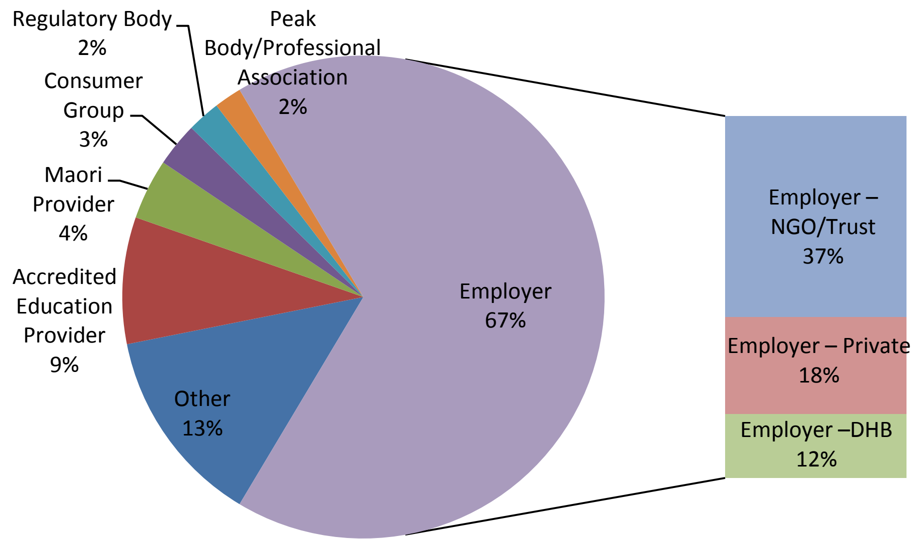


[2] Note: respondents could tick more than one sector.

3.2 ORGANISATION TYPE

The majority (67%) of respondents to the Scan classed themselves as drawn from "Employer" organisations. The largest type of employer organisation represented was "Non-Government Organisations/Trusts" (37%).

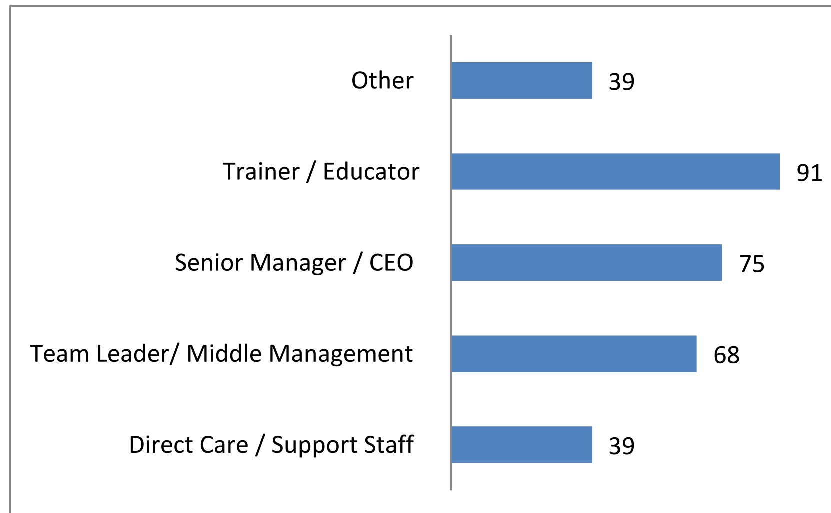
Chart 2: Organisations Represented



3.3 WORKFORCE ROLES

Respondents covered a wide range of workforce roles, encompassing Chief Executive Officers through to direct care/support staff.

Chart 3: Workforce Groups Represented



4 DEMAND AND ITS DRIVERS

Over 80% of respondents believed that the demand for health and disability support services is increasing. Only a minority (2%) suggested that demand was reducing.

4.1 WHAT IS DRIVING DEMAND INCREASES?

4.1.1 PUBLIC POLICY

The impact of public policy was identified as a key driver of increased demand (22% of respondents) for health and disability support services. The Ageing in Place Strategy[3] and the resulting movement towards providing health and disability support services in the community was repeatedly singled out as the key public policy driver. De-institutionalisation was also identified as a significant factor.

Responses relating to public policy included:

→ *Public policy - with the shift from institutional to community-base services.*[4]

→ *People are making a choice to remain in the community; however, public policy is guiding these choices.*

→ *Government policy of keeping people at home with home support until they are well past the rest home stage and need to enter hospital.*

→ *No planning after closing institutions for those who would reach adulthood in the future despite immense amount of lobbying by parents.*

→ *The pressure of early discharge from hospitals, and the Ageing in Place strategy, meaning that more people are cared for in their own homes rather than in care facilities or hospitals.*

4.1.2 CHANGING SERVICE MODELS AND ASSOCIATED COMPLIANCE REQUIREMENTS

Some respondents (12 %) commented that changing service delivery models were having a significant impact on the demand for, and delivery of, health and disability services. In particular, the shifting focus of service provision from maintenance and management to recovery and restorative approaches requires more resourcing: not only because services are increasingly delivered in community settings, but also because services need to be tailored to the specific needs of individual clients.

While the shifting focus of service delivery has been driven by both funders and service users, respondents indicated there has been no corresponding increase in resourcing from funders to ensure that the restorative model[5] was sustainable. Some respondents suggested that compliance demands had substantially increased as well.

Responses relating to changing service models and associated compliance included:

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[3] Ministry of Health: Health of Older People Strategy 2002.
[4] In the context of health and disability support services.
[5] See Appendix for a definition of the restorative model.

→ *We have changed the way we deliver services according to demands. Most of our support workers enjoy the new restorative or flexible delivery.*

→ *We are now providing a restorative model of service to some of our clients, working toward client goals… The challenges are that we now deliver a number of different types of care, some clients are still on a more traditional model, some restorative, some flexi/outcomes based, some palliative care… Limiting factors would be funding for the extra training and face to face contact that is needed for the support workers to ensure the new models are working well.*

→ *Demand has increased and so has the demands of funding agencies, including changes to contracts without subsequent increases in contract rates.*

4.1.3 DEMOGRAPHY

The ageing population was identified as a key driver of demand (12% of respondents). In particular, the ageing baby boomer cohort was singled out as a key forthcoming challenge for health and disability service providers.

Responses relating to demography included:

→ [*Demand has*] *increased and will continue to do so, because of an aging population.*

→ *General growth driven by growth in aged population.*

4.1.4 ECONOMY

Although the Scan took place before the severity of the deteriorating economic situation was fully understood, 11% of respondents indicated that the economic climate was already increasing the demand for their services, and that this trend was expected to accelerate.

It was indicated by some respondents that the deteriorating economic situation would also reduce the funding available to meet this increased need.

Responses relating to the economy included:

→ *Continued increase in demand particularly with the increase in social and economic pressures.*

→ *The current economy may push up numbers due to depression (loss of jobs, financial worries, low self esteem and social isolation).*

→ *We expect the economic pressures to add stress to our community and that more support, more referrals to counselling and budget advice and tenancy tribunals etc will be required. When those services are unable to accept referrals we will try to help our clients with their issues.*

→ *Recent changes will continue, but we also see that new challenges will emerge particularly as a result of the current economic climate. More people are likely to develop mental ill health, but they won't be the "typical" client service providers*[6] *are now seeing e.g. the top 3%. Providers and funders will need to find ways of*

[6] Providers of health and disability support services.

delivering services to this new audience before they end up "going through the system" to become part of the 3%, and there may not be the facilities within government to open up new funding streams.

→ *The worsening economic situation nationally has meant more stressed people, more unwellness, more seeking support.*

→ *The overall decline in the world-wide and therefore NZ economy is a major factor in the reduction in service hours available to clients via the DHBs and MOH.*

4.1.5 INCREASING CARE AND SUPPORT NEEDS

A key component of increasing demand was clients presenting with increasingly high and complex needs, with several respondents commenting that more clients now required support for more than one condition. Common among these conditions were issues associated with mental illness and addiction.

Responses relating to increasing care and support needs included:

→ *The complexity of services demanded is increasing, particularly in the clinical aspects of support.*

→ *Increase in services required for people with more complex and challenging support needs.*

→ *Higher acuity growth resulting from people remaining in homes longer, rather than entering residential care.*

4.1.6 INCREASING EXPECTATIONS

Increasing expectations from clients was a commonly cited driver of demand. People are demonstrating a preference to stay in their own homes and receive the care and support they need through home and community based services.

Changes to public policies and effective advocacy by client groups was identified as an important contributor to increased client expectations, as was increased knowledge of clients' rights, and a generally more informed public.

Responses relating to increasing expectations included:

→ *Knowledge of homecare services in the community. Choice to stay at home as opposed to going into a rest home or private hospital.*

→ *I think the move towards community based services has had a lot to do with this as has growing expectations that younger generations are not that satisfied with segregated options.*

→ *Increasing demands from a more demanding generation.*

→ *Increase in knowledge of services available and reduced stigma associated with accessing those services.*

→ *I think demand for disability services has increased particularly with Māori clients. They are becoming more aware of services that are available to them and seem to be accessing them more willingly.*

→ *Public policy mainly through client rights enabling clients to have more say in how their individual needs should be met and professional agencies being more aware of meeting the individuals needs and choices through rights*

4.2 HOW ARE ORGANISATIONS RESPONDING TO DEMAND INCREASES?

4.2.1 WORKFORCE DEVELOPMENT AND TRAINING

The most common response to increases in demand was an increased emphasis on workforce development and training (37% of respondents). Several respondents commented on initiatives undertaken to develop comprehensive training programmes for their staff. There was support for the development and fast-tracking of career pathways to enable people to progress through the sector.

Responses related to workforce development and training included:

→ *The organisation is now planning for a greater emphasis on workforce development to achieve minimum qualifications for all staff and the expansion of service models consistent with family and service user demand.*

→ *We are constantly enhancing our training to meet the requirements of our clients.*

→ *We have continued to provide education and support for staff...We have a full-time staff trainer to coordinate, facilitate and provide staff education. We have worked through peak bodies to encourage workforce development in the disability sector.*

→ *Workforce development - addressing recruitment, retention, organisational development, leadership, training and development.*

4.2.2 WORKING DIFFERENTLY

Organisations were also working to provide more flexible, client driven services (identified by 32% of respondents). Measures to increase flexibility of response included the provision of mobile and community support services, and operating outside the traditional 9am-5pm Monday to Friday working week, including late night and weekend service provision. These measures also encompassed working collaboratively with other health and disability service providers including Primary Health Organisations (PHOs), to provide more seamless care and therefore improving outcomes for clients.

Respondents throughout the survey highlighted a move away from a “doing/assisting” approach to a “supporting/coaching” focus. As part of this trend, more health and disability providers were seeking client input into the appropriateness of services.

Responses relating to working differently included:

→ *Mobile support teams are flexible and can be configured to reflect the needs of specific groups of service users.*

→ *Being involved in new initiatives with PHOs to better meet the needs of local communities.*

→ *Staff working more as partners than doing things “for” people - true equity.*

→ *Our organisation has looked closely at its origins, the services it delivers, and its relevance to the people we support. The resulting changes have meant increased demand for our services.*

→ *Increased emphasis on input from consumers into organisation at all levels, start of consumer led services, staff training in intentional peer support and person centred approach to service delivery. The approach to service has changed to one with a greater emphasis on restorative support, working with client goals, "working with clients not for clients", promoting independence, and outcome focused.*

4.2.3 INCREASING CAPACITY

Increasing capacity was identified by 19% of respondents as a key response to increasing demand. This capacity included providing additional services, recruiting new staff, installing more beds, and increasing the rate of capital investment and development of infrastructure.

Responses relating to increasing capacity included:

→ *We have employed greater numbers of staff to cope with the increased workload. Although this has hugely impacted on our wages bill it has also forced us to minimise wage increases.*

→ *We have increased the number of hospital beds in several of our facilities, and are expanding into retirement villages to help with supervised care, with a flow through to Rest Home and Hospital care to ensure aging in place applies for more people.*

4.2.4 RECOGNISING CULTURAL DIFFERENCES

New Zealand's changing demography and increasing recognition of the rights of Māori as Treaty partners have impacted on the way organisations are operating. The importance of working collaboratively with Māori, and Pacific Island and Asian communities, was identified by a number of respondents. Examples were provided of investments in cultural training in order to increase cultural responsiveness by organisations.

Responses relating to cultural differences included:

→ *Our organisation has grown e.g. engaged a Pacific coordinator, last year. We have an existing Māori coordinator.*

→ *Developing services for Māori. Māoritanga.*

→ *Ensuring the history of Aotearoa is clearly understood and articulated in terms of past to present effects on consumer/tangata whai ora, whānau/family and these communities.*

→ *Ability to work inclusively with family members in the context of their culture - mainstream as well as Māori, Pacific, Asian.*

→ *Pacific - we have a pacific programme to address responsiveness to a pacific population who are over represented in mental health statistics.*

4.3 DEMAND FOR SERVICES OVER THE MEDIUM TERM

The majority of respondents were expecting a demand for services to increase over the medium term (the next 3-5 years). The growth in client acuity and changing models of care were cited as issues that would continue to increase the demand for provision of health and disability services.

Responses relating to demand over the medium term included:

→ *A continuation of increasing demand for services, particularly home based and greater complexity and higher standards.*

→ *There will be a growth in more complex and high need clients.*

→ *Peer support increasingly important, and more peer/consumer led services.*

→ *Need for more collaborative and multi agency approaches and joint ventures.*

5 ROLES AND SKILLS

The top two roles identified as critical to fill were care and support workers[7] (55%) and Registered Nurses (RNs) (23%).

5.1 CARE AND SUPPORT WORKERS

5.1.1 ATTRACTING AND/OR RETAINING CARE AND SUPPORT WORKERS

The overwhelming issue identified as leading to difficulties in attracting and retaining care and support workers was lack of funding to pay staff adequately and provide good working conditions (39% of respondents). Many respondents discussed the importance of being appropriately funded to provide training to care and support workers, and to link their qualifications to pay rates (14%).

Other issues raised were the lack of perceived value attached to the role in the community; the part-time nature of the role; the lack of a career pathway and ability to progress professionally; and issues around the definition of "care and support worker".

Responses relating to attracting and/or retaining care and support workers included:

→ *They are underpaid and the saying goes if you pay peanuts you get monkeys, unless you are dedicated and love the Job. I have been a care giver for 17 years and in that time my wages have increased $5.00 an hour.*

→ *The role is poorly defined and interpreted in different ways by different providers.*[8] *It is generally undervalued or even unknown by many "clinical" workers. It is also poorly paid.*

→ *Clients'/funders' expectations are that a support worker will be able to do everything from clean a client's bathroom to assisting with client goal setting, accessing the community, safe meal preparation, continence management, medication assistance, assistance with transportation to appointments etc.*

5.1.2 POSSIBLE SOLUTIONS FOR THE CARE AND SUPPORT WORKER SHORTAGE

Increased pay and improved conditions for care and support workers was the solution suggested by 33% of respondents who cited shortages for this critical role. Enhanced training opportunities were suggested by 21% of respondents.

Responses proposing possible solutions for the current care and support worker shortage included:

→ *Making wages relevant for the job. A checkout operator can earn the same with far less responsibility.*

→ *Pay and conditions that recognise training and skills - at present there is no incentive to upskill, once upskilled most people leave for higher paid better recognised areas of work.*

[7] See Appendix for a definition of care and support workers.
[8] Health and disability providers.

→ *Recognition from funders that the skill set required to support new models of service delivery required within specifications requires additional training which is no longer affordable within current funding level – consider funding targeted at training for this group.*

→ *Linking of qualification achievement to salaries across the health and disability field in such a way that it makes the field an attractive proposition for potential employees. Obviously there would need to be corresponding funding to support this.*

5.1.3 CRITICAL SKILLS AND TRAINING NEEDS FOR CARE AND SUPPORT WORKERS

Respondents identified three key critical skills that care and support workers needed to possess:

- Communication and interpersonal skills (representing 27% of the critical skills identified);
- Team leader/supervision/management skills (22%);
- Discipline specific skills (20%).

Training or skill development needs identified for care and support workers included a range of accessible and supported training options (including night and weekend classes and interactive learning aids); the development of higher level qualifications to reflect the importance of the role; better support for those workers with English as a second language; leadership and supervision skills; making training mandatory; and a career pathway which allowed care and support workers to follow a variety of specialist subject areas.

Responses relating to critical skill and training needs for care and support workers included:

→ *I believe that all caregivers should undertake compulsory training. We are letting untrained people in to take care of our elderly. Is there any other place in the health care system that we would do that?*

→ *Encouragement and support for those with English as a second language.*

→ *A combined approach to government/DHBs re adequate resourcing for training for support workers, advanced support workers and first line management.*

→ *Compulsory qualification (be that NCCSS Foundations) for all staff working in the direct support worker role. This will happen if Govt as funders require it. A satisfactory training method has yet to be established. What are the incentives to study when the rewards are not tangible?*

→ *The area of training is becoming more complex as the work done by those in the field is expanded. Often workers are expected to perform at a level above their training.*

→ *I have over 30 staff who have National Certificate in Support of the Older Person. They have reached the ceiling. They all wish to become enrolled nurses (at least $5 more per hour for this qualification) but have nowhere to go. They are excellent care workers and would benefit hugely from becoming an enrolled nurse.*

5.2 REGISTERED NURSES

5.2.1 ATTRACTING AND/OR RETAINING REGISTERED NURSES

As was the case with support workers, funding and pay were seen as the key issues with respect to attracting and retaining RNs (cited by 50% of respondents who identified RNs as a critical role). The issue of RNs being able to receive more money either by working for the local DHB or going overseas was raised repeatedly.[9]

Some respondents commented that the English language competency requirements for overseas trained nurses acted as a barrier to recruitment.

Responses relating to attracting and/or retaining RNs included:

→ *They can earn $20k + more at the local DHB!!!*

→ *The pay scale is still not attractive and certainly not competitive globally so we lose too many nurses overseas. The disability/mental health sector is not seen as a preferred career choice for nursing and that is unfortunate also. Hospital nursing in medical and surgical areas is seen as (and I quote several colleagues) "real nursing".*

→ *Shortages of RNs is worldwide and not helped by NZ Immigration Service and Nursing Council of NZ.*

5.2.2 POSSIBLE SOLUTIONS FOR THE REGISTERED NURSE SHORTAGE

Increased pay and improved conditions for nurses was the solution suggested by 44% of respondents who cited this critical role as hard to fill.

Other issues identified for RNs included relaxing English language requirements to make it easier for overseas workers to practise in New Zealand, and enabling RNs to delegate more work to senior support workers.

Responses covering possible solutions for the RN shortage included:

→ *Equality of salaries and employment conditions with MECA.*

→ *Make it easier for overseas trained RNs to work in this country, decrease the English requirement to a slightly lower level.*

→ *Some more money would help but a very strong support system would also help. Nurses working with these very distressed people need reliable management support and counselling to offset the effects of the work.*

[9] Recent anecdotal evidence suggests that further deterioration in the global economic situation since the Scan was undertaken has reduced the number of Registered Nurses relocating overseas and increased the number of expatriate Registered Nurses returning to work in New Zealand.

5.2.3 CRITICAL SKILLS AND TRAINING NEEDS FOR REGISTERED NURSES

Respondents identified two key skills that nurses needed to possess:

- Team leader/supervision/management skills (36%);
- Discipline specific specialist skills (29%).

Discipline specific specialist skills included areas of specialisation such as disability, recovery, and mental health and addiction. Respondents also indicated the importance of enhancing team leadership, mentoring, and supervisory skills, and increasing nurses' understanding of contractual and compliance requirements.

Responses relating to critical skills and training needs for RNs included:

→ *Competency checked staff taking on greater responsibility.*

→ *Clinical skills, leadership development.*

→ *Regular, cheap or free on-site training [for Registered Nurses].*

→ *Management, documentation policies and procedures, meeting DHB contract requirements, audits.*

5.3 CRITICAL SKILLS NEEDED FOR ALL WORKFORCE GROUPS

Throughout the Survey respondents detailed a number of skills they saw as critical for workers who are employed in the health and disability support sector. The following critical skills were identified as common to all workforce groups:

- Communication skills.
- Advocacy skills.
- Addressing challenging behaviour.
- Conflict resolution.
- Empathy.
- Problem solving skills.
- Discipline specific/clinical skills.
- Understanding The Code of Rights.
- Cultural competency.
- Goal setting.
- Competencies in administering personal cares.
- Working with older people with mental health conditions/dementia.
- Team leader, management and supervision skills.
- Case management.

5.4 NEW OR CHANGING WORK ROLES

Very few new roles were suggested by respondents, most of whom focused on the need to expand the scope of existing roles. Changing work roles indentified included:

- Continued expansion of the community worker role.
- The need for specific supervisory roles.
- The need for greater specialisation by staff in areas where there are increasingly complex and multiple diagnoses.
- The need to be able to work with, rather than for, clients (i.e. a move to a partnership approach).

These roles, and the related critical skills, were recurrent themes throughout the survey responses.

Responses relating to new or changing work roles included:

→ *Would like to see senior community support workers who are well trained and able to work effectively in remote rural communities - ability to be the eyes that observe change and communicate that back to other health professionals for follow-up.*

→ *People who are able to work holistically across mental health, addictions and pre-aged and aged care.*

→ *The role of a kai tau toko ā. A person who works with clients to change their behaviour and to learn to self-manage their condition – a coach.*

→ *Supervisor role - involved far more in quality of service and organisational areas.*

→ *Build in health promotion/prevention as part of everyone's position.*

→ *A group of staff who are supporting adults with a Dual diagnosis- ID*[10] *and mental health illness - This requires a very specific skill level.*

→ *There will be many varied and exciting changes with the development of the Retirement Village, which will definitely push people to find that bit extra inside themselves. This will require the RNs particularly to step outside their comfort zones.*

[10] Intellectual disability.

6 TRAINING

6.1 BARRIERS TO TRAINING

Funding was identified as the most significant barrier to training (cited by 35% of respondents). Respondents reported inadequate funding to pay for, and deliver, training over and above their contracted service functions. Providing cover for staff to attend training was repeatedly cited as a key cost. The need for workplaces to utilise their own staff to support education (i.e. employing assessors, facilitators and educators) was also identified as a cost and a barrier.

The time commitment required to support staff who were undertaking qualifications, together with the personal time commitment of the trainees themselves, were cited as a barrier to training by a large number of respondents. Difficulties providing training and support for staff with literacy issues, and for those with English as a second language, were also identified. The lack of relevant and transferable qualifications, difficulties motivating staff to commit to training, lack of incentives, and issues surrounding the retention of staff once they are trained were other barriers identified by respondents.

Responses relating to barriers to training included:

→ *Lack of funding to support level of training. Ability to release staff for training due to shortage of suitably qualified/experienced workers. Nature of staff employed - many have not studied before and therefore resist any change in requirement to up skill or if they accept require significant support to achieve.*

→ *Lack of paid time to allow workers to be released to undertake the training. Lack of workers to cover while others are out training. Low self-esteem in the workers who may not have had good study experiences. Poor literacy.*

→ *The wages we can offer. We severely underpay our staff and still attract very effective applicants but as they gain skills we cannot compete with those who have bigger budgets. We would love to offer real financial support to the staff that take on study to improve their position but we can't. We have too small a training budget and can't afford to release our staff from their work to study.*

→ *Limited resources to (1) support skills acquisition; and (2) retain skilled staff…Largely unskilled workers with limited success in learning settings…Organisations with scarce capacity that have to provide assessors, moderators, facilitators, to make it work…Failure to agree to transportable qualifications.*

→ *Finding the time to study and complete training outside work hours.*

→ *Once people gain knowledge and skills they move to higher paying positions outside the company.*

→ *Sheer volume of workers and their widespread locations.*

→ *We are decentralised and many of our clients/staff work rurally.*

6.2 QUALIFICATIONS AND TRAINING OFFERED

Approximately one quarter of respondents indicated that training was available to assist staff to complete national qualifications. Over 70% of those organisations offering national qualifications to their staff delivered these qualifications themselves through a workplace based model; nearly 36% utilised a Polytechnic or Institute of Technology (ITP); and over 18% were delivered by a Private Training Establishment (PTE). These percentages combined indicate that some organisations utilise a combination of educational approaches to offer national qualifications to their staff.

A wide range of local qualifications delivered by ITPs and PTEs is also offered to staff, in addition to a variety of in-house training courses in specialist areas such the Treaty of Waitangi, bi-culturalism, professional supervision, presentation skills, health and safety and first aid.

6.3 POSSIBLE CHANGES TO NATIONAL QUALIFICATIONS DELIVERY

A relatively small number of respondents replied to the question of possible changes to the delivery of national qualifications. Of those who responded, their suggestions were wide ranging. A sizable proportion was happy with the status quo or expressed positive statements about current delivery options.

A number of respondents suggested that assessment processes required review, and that increased support for assessors was needed (an issue reiterated throughout the Scan). Other issues identified included the confusion and unnecessary duplication resulting from having both local and national qualifications available; and confusion surrounding the relationship between Health Education Trust and Careerforce.

Respondents from the mental health and addiction sectors suggested that there was a need for a lower level, workplace-based national qualification, in addition to the Level 4 and Level 6 mental health national qualifications currently being delivered through ITPs and PTEs.

Responses relating to possible changes to the delivery of national qualifications included:

→ *More support from ITO for the assessors in the workplace.*

→ *Love Careerforce and the training that is offered. Like the delivery, the books, the concept of working and assessing in the workplace and utilising the policies and procedures.*

→ *Mental health national qualifications pitched too high and not delivering the real skills needed by staff.*

→ *Polytechs each seem to have a mind of their own. There are nationally developed quals that they choose not to deliver because they feel they can build something which is better, and although it is approved by the National Qualifications Framework it seems dumb to have all these different quals and people spending effort developing and sitting them when there is a national document put together with nationwide industry input. Multiple qualifications in the same field seem to me to be confusing and just plain dumb.*

6.3.1 TOPIC AREAS TO BE INCLUDED IN FUTURE NATIONAL QUALIFICATIONS

A wide-ranging number of topics were identified by respondents for possible inclusion in future national qualifications. These topics largely correspond with the critical skills needs identified in earlier parts of the survey (and summarised in Section 5.3).

An issue raised repeatedly was the need to improve the understanding of mental health and addiction issues, either by integrating this information into the current Level 2 and/or 3 national qualifications, or by creating a separate, lower level, mental health and addiction national qualification.

Responses relating to topic areas to be included in future national qualifications included:

→ *There are generic competencies that should form the core of all workers' competencies, and Careerforce has identified most of these already. These will be discipline-specific competencies that need to be identified by each discipline.*

→ *Health and disability service management, or people adequately trained in management for the sector are quite obviously lacking. Good practitioners do not necessarily make good managers, and are generally not inherently able to step from being a practitioner to being a manager without additional training and skills being required. Similarly, managers from the private sector (outside the health and disability sector) do not necessarily make good managers in the sector. There is a need for health and disability management training.*

→ *Training that takes into consideration the immigrant groups who may require language and cultural training.*

→ *We would really like to have a workplace based mental health certificate - level 3 at least, and level 4 would be great!*

7 PRIORITIES FOR ACHIEVING A SUSTAINABLE AND SKILLED CARE AND SUPPORT WORKFORCE

Training and funding issues dominated the priority actions provided by respondents.

Training, including provision of time to study and supports to improve training outcomes (including literacy support), was regarded as the top priority to support the development of a sustainable and skilled care and support workforce (42% of respondents).

Funding issues, including pay rates, were identified as the top priority by 17% of respondents. Common funding issues identified included the need for funders to resource health and disability workplaces adequately so that they were able to pay staff at equitable rates; fund training and meet some of the resulting costs (including the costs of providing cover for staff in training); and devise incentives that would increase the uptake of qualifications. Increasing funding to remove the disparity between DHB levels of pay and the amount that other health and disability providers can pay staff was also identified as a priority. This concern related to salary scales/pay rates not only for RNs, but also for care and support workers.

It was suggested by some respondents that more financial support was required to establish a training and professional development infrastructure.

Responses relating to priorities for achieving a sustainable and skilled care and support workforce included:

→ *Money and time available to study - the right courses.*

→ *Pay rates offered to providers*[11] *(and so passed on to workers) reflect where the Government sees the workforce. Until they truly appreciate the work being done, how can we expect others to value the role?*

→ *To link training to wage levels - training cannot advance independently.*

→ *Framework developed to meet needs of employers, demands and communities.*

→ *Provide extra funding for training.*

→ *Better pay and working conditions (e.g. paid course fees; paid time at a training institution, "day release") including strong support for staff to continue formal education and training.*

→ *A nationwide commitment to one "group" of qualifications that is accepted by all e.g. not one from MIT, one from Unitec, one from Careerforce, ACE, others from PTEs etc.*

→ *To link training to wage levels - training cannot advance independently*

→ *Effectively market careers in the health and disability sector as great opportunities for young people entering the workforce.*

[11] Health and disability providers.

7.1 CAREERFORCE ACTIONS IDENTIFIED

Responses to key actions that survey participants would like Careerforce to prioritise or do differently were highly varied.

Qualification development and the acceleration of career pathways for the sector were mentioned by a number of respondents.

Respondents also suggested that an important priority for Careerforce was to provide greater support to make the assessment process more straightforward. Suggestions included improving assessor training; providing examples of best practice; outlining what the assessment of each unit standard actually involves; providing greater scope for assessors; and simplifying the language used in workplace assessment portfolios.

Several respondents from sub-sectors which have lower level national qualifications available suggested that Careerforce's priority needs to be on developing higher level qualifications. Interestingly, for respondents from the mental health and addiction sector which currently offers national qualifications at Levels 4 and 6 on the National Qualifications Framework, the identified priority was on the development of a lower level, workplace-based national qualification.

Also noted was the need to increase levels of support for workplace educators delivering training, and to provide a variety of learning aids to complement current workbooks.

→ *Training at all levels - from basic caregiver to rest home manager.*

→ *We love the foundation skills, core competencies and service stream Level 2 and 3 qualifications you are putting in place now. We just want it for all services not just 2 or 3.*

→ *Make the workbooks easier to understand for those with poor literacy or English as a second language.*

→ *Ease of access to qualifications - simple language, access to support, seamless admin.*

→ *The assessment and verification requirements should match the qualification level and not pose an unrealistic burden on providers[12] that are not funded for an intensive training and development infrastructure.*

→ *Extending the Level 2 and Level 3 Careerforce Pathway Qualifications to include higher level qualifications.*

→ *Fund or make provision for a training and development infrastructure that can provide assessment and verification of unit standards without siphoning resources from service delivery.*

→ *Invest in more training programmes for the trainers.*

→ *Stop focusing on Level 2 and 3 and accept and acknowledge that there is a very high level of skill workers in the current workforce, who have no access to higher level relevant training.*

[12] Health and disability service providers.

→ *Develop L4, 5 and 6 qualifications to bridge the gap between existing qualifications.*

→ *Develop resources such as DVDS, interactive computer programmes etc to complement workbooks.*

→ *Mental Health national qualifications pitched too high and not delivering the real skills needed by staff.*

→ *Be clear on what and when things will happen and make sure they do…on time.*

→ *More support for assessors in the workplace e.g. Guide outline of what each unit standard involves.*

APPENDIX: KEY TERMS

CARE AND SUPPORT WORKFORCE DEFINITION

The care and support workforce includes all people (in either publicly or privately funded organisations) who provide care and support at the individual or community/population level throughout the continuum of health, disability and community settings (including home-based, community, residential and hospital); and who are not subject to the direct regulatory requirements of the Health Practitioners Competence Assurance Act 2003 or the Social Workers Registration Act 2003.

The care and support workforce covers a broad range of role types including, but not limited to: addiction support workers, allied health assistants, childcare workers, community and home-based carers/caregivers, dementia support workers, disabilities service officers, disability needs assessment and service coordination workers, diversional therapists, family support workers, health care assistants, kia āwhina, Māori cultural support workers, mental health support workers, orderlies, Pacifica cultural support workers, peer support workers, public health workers, rehabilitation support workers, residential care officers, residential care workers, respite carers, whānau ora workers and youth workers.

This workforce includes paid and unpaid workers (for example family/whānau carers and volunteers), but excludes ancillary staff (e.g. ward staff, receptionists, typists, telephonists) and food and laundry service personnel.

RESTORATIVE MODEL DEFINITION

The restorative model refers to an integrated continuum of care that embodies the principles of people, their carers, families, and whānau participating in and receiving proactive, multidisciplinary, flexible, coordinated and responsive support. This support is consumer directed, goal orientated, strength based, socially orientated and outcome focussed to enable people to live as independently as possible and to participate at an optimal level in their communities for as long as possible.