



# COVID-19 Response Project Phase Two Report

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Consultation Draft

# 1 EXECUTIVE SUMMARY

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COVID-19 is reshaping the narrative and priorities about the provision of healthcare globally and we are all aware of the impact that the COVID-19 pandemic has had on frontline healthcare workers.

They have been challenged with an ongoing revolution of new instructions, processes, and the need to change on demand, be more agile in their workplace and achieve this whilst maintaining the safety of their patients and themselves. This applies to everyone working directly with patients and includes healthcare support workers.

Many have been 'repurposed' and asked to work doing things that were previously unfamiliar to them. There has been little discussion about the tremendous impact this pandemic has had, and will continue to have, on healthcare support workers moving forward. However, everyone agrees that their role has changed just as it has for doctors and nurses.

During Covid-19 lockdowns, there was a significant drop in proactive training activities (structured or informal) within the workplace with trainees undertaking Health and Wellbeing programmes of industry training where workplace-only models of training were utilised.

Even as organisations across the country continue to grapple with the immediate impact of COVID-19, leaders are also beginning to plan for the future. The pandemic is reshaping and restructuring the sector in ways that are likely to be permanent. While all can agree that the post-Covid landscape is likely to look notably different from the pre-Covid reality, there is considerable debate about the degree and nature of change the industry will experience.

Analysis using a Pre-Post COVID quadrant measured the changes in skills already being experienced in healthcare highlighted important changes in the balance and importance of different skills and knowledge affecting the roles that Careerforce develops qualifications for.

There are obvious practical skills that have increased in importance such as the use of PPE and infection control as well as other areas that have evolved during the year. These include risk management, the use of technology and managing clients remotely and effectively.

The fluid nature of these skills and the environment trainees are working means that the relevance of any training, advice or practical application can decay quicker than ever before. The fixed nature of traditional content can no longer be relied on. The structure and modes of delivery employed to train people also needs to be flexible and dynamic enough to adapt to changing skill areas as well as improving access and equitable quality of training.

Many of the changing skill areas could be further broken down into micro-learning and where feasible assessed via stackable micro-credentials that can be updated far more effectively using more agile-based iterative methods of development and review.

For medical and allied health professionals, continued medical education (CME) is required to ensure that, even after qualification, knowledge, methods, practice, and techniques are maintained. Continued education and training enable people in the medical field maintain competence and learn about new and developing areas of their field. In CME, these activities may take place as live events, written publications, online programs, audio, video, or other electronic media.

A similar model could be developed to maintain relevance for other healthcare workers. A framework of delivery and acquisition of skills and knowledge consistent to that of CME is similar to a model which utilises a multimodal form of delivery of content.

Blended learning in this context is considered as a single training and educational activity designed for the same learner(s) that is available and delivered via multiple formats from the same content or skill acquisition.

Blended learning activities tend to be delivered in two or more of the following formats.

- Live interaction and courses
- Enduring and fixed materials
- Medical based information, processes, and readings (e.g. case studies)
- Skill demonstration, performance, and improvement
- Point of care interaction and follow up.

Regardless of how an individual gains the required knowledge and skills to perform and grow in their role and career, they should be able to choose a range of delivery options that suit their personal style and environmental situation.

## 1.1 SUMMARY

- In times of uncertainty there was a significant reduction in the volume in proactive training when it is needed most.
- The half-life of knowledge is reducing and therefore current content is becoming out of date quicker.
- Many of the core skills for trainees are changing in importance.
- Breaking modules down into micro-learning and potentially stackable micro-credentials will allow for changes quicker.
- Trainees need to be able to change how they acquire skills and knowledge as their situation and environment changes.
- CME is used by medical professionals to learn new skills and maintain existing ones. They are able to acquire points (credits) from a variety of channels that are accumulated (stacked) towards their ongoing registration.
- A similar model could be considered for the wider health and wellbeing workforce (kaiāwhina and kaimanaaki<sup>1</sup>)
- Blended learning for all trainees and apprentices will allow each to decide, change and progress with the more of training that suits them best.
- Changes in the healthcare environment impact existing healthcare workers as well as trainees. There is an opportunity to provide access to these micro-credentials and content to existing staff as well.

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<sup>1</sup> Kaiāwhina and Kaimanaaki are collective terms used to describe people who work in non-regulated roles in healthcare and social services.

## 1.2 RECOMMENDATION SUMMARY

### 1.2.1 Environment Recommendations

- Identify and analyse what is changing specifically for healthcare support workers in target sectors.

### 1.2.2 Training Methodologies and Material Recommendations

- Agree which skills are new, need updating or are now irrelevant for the roles that relate to each targeted qualification.
- Develop an integrated blended learning model for employers and employees that suits different learning styles and organisational type.
- Develop cross-organisation trainee networks to improve quality, consistency, and equality of training.
- Foster a culture of collaborative and continuous learning
- Introduce social influence through self-directed groups
- Use, invest and develop Aka Toi further
- Make all training materials accessible 24/7
- Drive and develop stackable micro-credentials for high change, high demand areas

### 1.2.3 Employer Recommendations

- Be the expert and anticipate.
- Create a supportive learning culture.
- Develop supportive learning cultures.
- Make learning experiential for employees.

## 2 INTRODUCTION

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The experience of the last year has demonstrated the potential for fundamental shifts across the care continuum. These shifts include the design and construction of facilities, the training of healthcare workers, sourcing and inventory management of critical care equipment and personal protective equipment (PPE) materials, and the optimal settings for care delivery and how it is managed. Some of these shifts were underway before the pandemic was declared and they have now accelerated.

The healthcare response to COVID-19 will remain a priority for an anticipated 12 to 18 months, as countries implement phased relaxations and restrictions to suppress the virus, expand testing and treatment capacity, and gain access to vaccinations.

The future success of healthcare providers may be determined by the ability of their staff to adjust to the next normal, dealing with a specific set of new or accentuated challenges, and capturing new skills at speed.

Remote working and remote learning were gaining momentum before the crisis, but the pandemic has accelerated this trend. For example, 41% of employees are likely to work remotely at least some of the time post coronavirus pandemic.<sup>2</sup>

Although many employees “learned by doing” during the first phase of the crisis or received “quick and dirty” training, continued remote working will probably keep posing an upskilling challenge.

For example, some trainees have already been recognised for using their own initiative to prepare ‘packs’ for their patients and have learned how to communicate differently when working with patients remotely. This includes the shift from setting up video meetings to managing workload effectively in remote settings.

Employers also face a fast-learning curve as managers figure out how to lead their teams in a mixed face to face and virtual world as they themselves reskill in how to maintain quality of service and cohesion without the benefit of proximity and the ambiguity of an impending community outbreak of COVID-19. As organisations contemplate the long-term impact to the healthcare workplace, a new set of skills not yet completely realised is also likely to emerge for the transition.

People working in healthcare will need to continuously reskill, upskill, and adapt. There are examples of talented people who are achieving and innovating under their own initiative. However, there are many more people who will be struggling and waiting to be guided, trained, and empowered to adjust what and how they work as their work environment changes. This affects more than trainees and apprentices. It impacts all people working in healthcare.

As the TITO, Careerforce supports workplace-based training, enabling employees to achieve nationally recognised qualifications, and deliver improved outcomes across the health and wellbeing sector. To continue that, the content, skills and how they are made accessible to trainees and apprentices needs to reflect the COVID-19 change environment.

The learning landscape has changed in ways that will foster teaching new skills to employees, wherever they may be. For example, COVID-19 has accelerated the acceptance of fully digitized approaches to re-create the best of in-person learning through live video and social sharing.

This transformation makes it possible to scale learning and training efforts in a more dynamic, on-demand and cost-effective way. It permits greater personalisation for learners—and in turn greater effectiveness.

### 3 PURPOSE AND OVERVIEW

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The purpose of this project is to explore how the TITO/WDC can position itself ahead of these changes and any disruption those changes may incur. This project is enabling the TITO/WDC to.

- Develop greater understanding and thought leadership of changes in new knowledge and skills facing employers and employees.
- Work with industry to refine, design and implement changes and redesign in content, focus and mode of delivery in targeted programmes.

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<sup>2</sup> <https://www.gartner.com/en/newsroom/press-releases/2020-04-14-gartner-hr-survey-reveals-41--of-employees-likely-to->

- Support and enable a quicker recovery and adaptability of Health and Wellbeing, and Social and Community services.

The goal is to ensure that e TITO/WDC, trainees, apprentices and their industry partners are looking to the future. That they are prepared, ready, and enabled to work with their stakeholders to deliver the right knowledge and skills their workforce needs.

Any training or upskilling in this environment needs to be identified early, available in the right place, at the right time and using the most optimal methods for delivery, moderation, assessment, and certification.

The project will redefine how programmes are adapted and structured to align with the choices and needs employees are experiencing.

Flexible pathways and modes of delivery for trainees and apprentices are vital for both on- and off-job training as is the ability to change focus onto areas that are more important to the workplace than others.

## 4 POST-COVID THEMES

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There are several themes emerging in healthcare that will be instrumental in influencing and guiding the actions and reactions of industry post-COVID. The key themes include.

### 4.1 SELF-SUFFICIENCY AND INITIATIVE

- The ability and confidence to use one's own initiative and develop greater self-sufficiency will become greatly valued.
- For individuals and organisations, COVID has exposed an over-reliance of current (pre-COVID) systems and processes that may have led to compromises in quality, relevance, or consistency of service.
  - In this case the consequence in the relevance and quality of on-going training for trainees and staff in healthcare.
- Soft skills such as initiative, problem-solving and communication skills etc. were important before. They are becoming even more so during and post COVID.

### 4.2 RESILIENCE AND ADAPTIVENESS

- One of the most critical roles right now is how to maintain focus and quality of service. The fatigue, stress and weight of expectation experienced by people working in healthcare are apparent in New Zealand and even more so globally.
- Whilst New Zealand is fortunate in terms of low COVID levels and none in the community, the government is constantly calling for vigilance and the avoidance of complacency.
- TITO/WDC have an opportunity and obligation to ensure that employees and industry are in the best position to adapt and react.
- Trainees, apprentices, and existing staff must be able to effectively act and make critical decisions under conditions of uncertainty. To think and act in these conditions requires resilience.
- After a crisis comes recovery. With many assumptions in the way we work being challenged by the pandemic – from sudden changes in processes, approaches, security,



- confidence, etc. – governments, public authorities and businesses need to rethink, adapt and recover.
- This ability to adapt and flex effectively will be a critical and highly valued skill.

## 5 TRAINEES AND EXISTING STAFF

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The education and training of trainees as well as the existing workforce, along with the preparation of an appropriate pipeline of talented future staff, will be key to the success of any programme of change designed to empower staff to effectively adapt to the consequences of COVID-19 and continue to improve service delivery.

### 5.1 DIGITAL LITERACY

Today, the delivery of care largely centres around the attendance of patients in face-to-face environment. Already remote delivery of care to patients is becoming more prevalent via telemedicine. This is having an impact on many existing trainees, apprentices, and staff. The healthcare workforce and patients are training and adapting by themselves in how to change how they communicate, interact, and develop new pathways to care, support, diagnose, monitor, educate and treat patients.

The expansion of ‘hospital at home’ schemes internationally will allow more acute care remotely. Patients will stay in their own homes whilst receiving extra care and attention from their health support team.

These schemes are designed to give patients extra support at home using other methods of interaction and utilising technology more effectively. This will reduce pressure on other areas of health and manage demand for care.

The implication of this will be the delivery of high-quality personalised care regardless of location (home, care home, pharmacy, community hospital or acute hospital). This will be enabled by people with the appropriate skills and the right technology in place supported the development of policies that reflect the new world.

#### 5.1.1 New Direction

There is an opportunity to redesign training and assessment around trainee journeys and evolving skills rather than a structured and inflexible approach. The development and delivery of skills needs to be more agile and flexible, have more resilience with fewer single points of entry and failure, and harness the understanding of what motivates and engages the trainees.

Continued interaction and engagement with industry, whilst maintaining a thought-leadership position, will increase value to employers and build the goodwill and momentum of the past 12 months of changes.

## 6 INNOVATION AND AMBITION

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Over the next two years health and care systems will need to experiment and embed new models of care and support. Which innovations will be carried forward and what skills will keep evolving to address new requirements?

As the Ministry of Health improve their understanding, policies, and practices in response to COVID-19, one of the biggest risks to patient satisfaction and quality of care will be the effect COVID-19 has had on all the other demands for health and social care services. The longer it takes for healthcare organisations to adapt to the new environment, the more workforce disruption will be caused, and the level of care and service will be compromised.

Solutions to many of these challenges are down to the skills and knowledge of new and existing staff. Digital communications and technologies are also being embraced at a scale never seen before. Home and personal remote monitoring will be tested and introduced. As the pressures subside, the temptation to revert to the status quo will grow. However, as the current surge in COVID-19 cases internationally have demonstrated, the expectation should be that different methods of care and support such as virtual and remote may be conducted by default rather than by exception.

## 7 REDUCING HALF-LIFE OF SKILLS AND KNOWLEDGE

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Employers now need to distinguish between crisis-induced short-term changes and more permanent shifts and the skills, knowledge and expertise required to address these changes. The landscape of our economy will settle and move and then settle and move again. The consequences of this is going to constantly and subtly change the blend of skills and knowledge require to work on any job. Any new or existing skills will shift and become less relevant quicker.

Therefore, any review, refinement, redesign of the delivery of training needs to be able to adapt and reflect the emerging changes in the work environment

Short- and Medium-term skills requirements will drive Long-term industry dynamics and culture. The value of in-work training will be enabled by content and delivery methods that are also dynamic, flexible, and adaptable whilst being structured, consistent and quality driven.

Everyone recognises that it will be different at all levels; and as illustrated in the key themes, we also need to be resilient, self-sufficient, and adaptable. These characteristics are critical for learners and employers and they are going to be much better equipped and enabled if resource developers can anticipate, refine, and innovate for them, before they need it.

Resource developers will develop the most optimal, dynamic, and flexible mix of training modes to suit and adapt to the environment. If skills and knowledge were in one room, then there needs to be more than one door into that room. Different entries that accommodate a variety of approaches. We need to assess in a variety of ways that are a hybrid of demonstration and practical with blends of delivery and application.

Multiple and interchangeable modes of delivery and content for same programme requires imagination, creativity, an open mind, and an acceptance to create and iterate.

## 8 PRE AND POST SKILL DEMAND QUADRANT

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The skill demand quadrant was developed to assess and predict the relationship between the skills that were in demand before COVID-19, the skills that are in demand now and how there will change in the short to medium term.

This model is being used to identify, discuss, and assess which specific skills, modules, and knowledge are trending up or down in importance due to the changes driven because of COVID-19.

### 8.1 SKILLS IN DEMAND PER-PANDEMIC

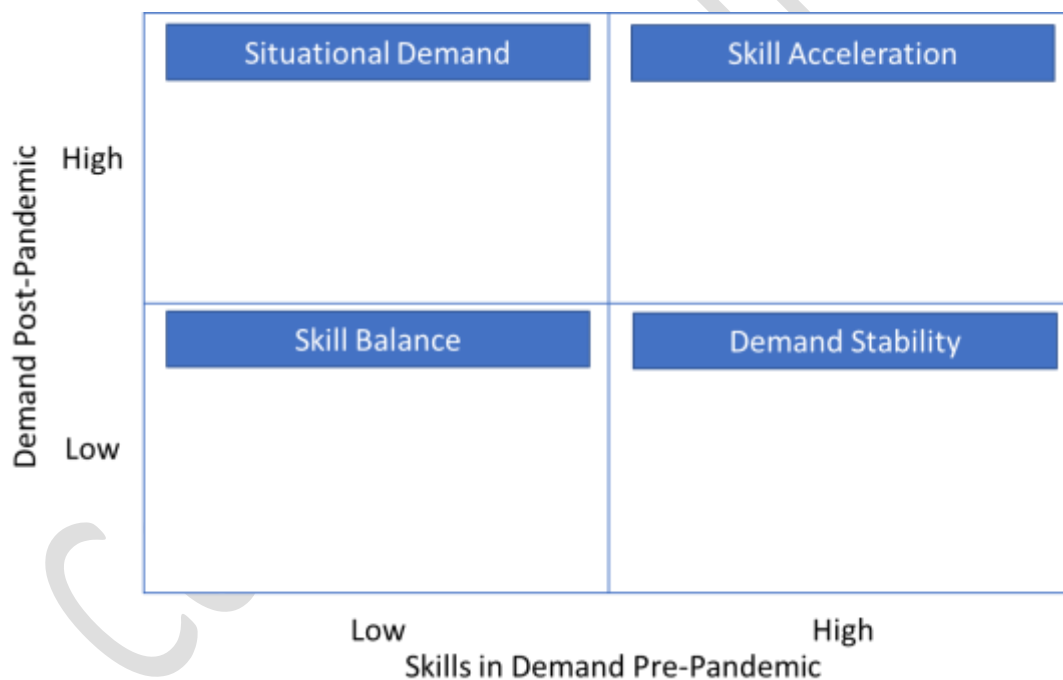
These are the skills and knowledge required to become proficient in a particular area before COVID-19 gained a foothold in our lives. There will be skills that were in high demand, were of high importance before the pandemic or skills that were of moderate or low importance.

### 8.2 DEMAND POST-PANDEMIC

There will be several skills, and new knowledge required now and after COVID-19 that weren't as important (if at all) last year. So, these skills will have moved from a low importance to high.

### 8.3 PRE-POST MODEL

The model below considers both factors. The demand of skills before and after the effect of COVID-19. An example of this will be the knowledge, process, and implementation of PPE within a rest home, hospital, or aged care facility. This skill and knowledge are now highly required but was low before COVID-19.



## 9 OVERVIEW OF THE COVID-19 SKILL DEMAND QUADRANT MODEL

There are four quadrants in this model. Each skill and area of knowledge will be considered in terms of the level of demand pre and post the COVID-19 pandemic. Based on the research, knowledge, and discussion in phase two, each skill will fit into one of these four quadrants.

This will enable the team to establish where to focus during this process to ensure the balance and priority of skills and knowledge match the emerging demand and value within the markets and employers we serve.

#### 9.1.1 Situational Demand – High Post, Low Pre Covid-19

These skills were not in such demand before the crisis but will become more important post-pandemic. Likely to surge in the short term and plateau as markets transform.

#### 9.1.2 Skill Balance - Low Post, Low Pre Covid-19

Skills that may be popular and useful. There is a balance between supply and demand for these skills before and after the pandemic. These will be nice to have but not essential.

#### 9.1.3 Skill Acceleration - High Post, High Pre Covid-19

Skills trending in high demand that have accelerated post pandemic. Demand is far greater than supply, especially in the short- and medium term.

#### 9.1.4 Demand Stability - Low Post, High Pre Covid-19

Skills that were in demand before the crisis. Demand will be largely unaffected, but they will still be demand.

## 10 INTERNAL EXPERTISE AND REACTION

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Several workshops were conducted with key staff from the TITO. These included.

- Wellington based Agile team currently reviewing NZ Certificate Level 3 specialisms,
- Product Managers for the Level 4 apprenticeship programmes,
- Staff assessors on the Diploma L5 programme.

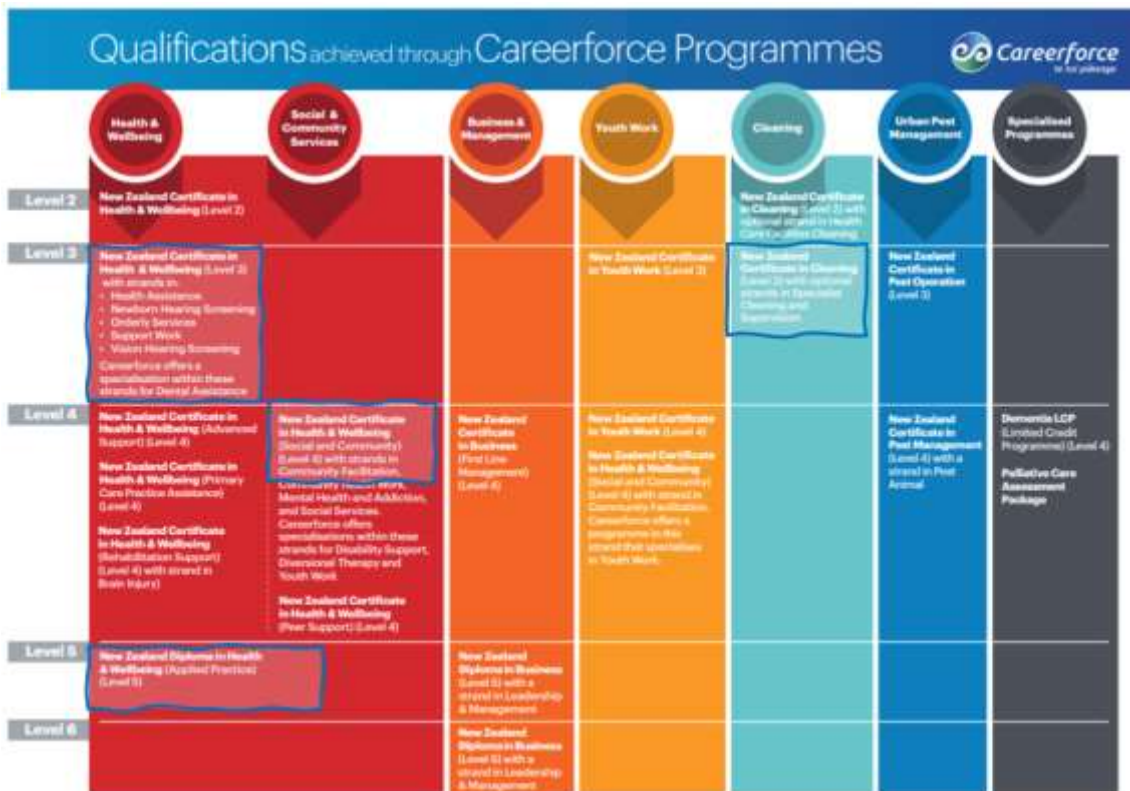
The purpose of these workshops was to identify, discuss and assess which skills need to adapt, the current changes and consequences in skills and the work environment and what would become of these skills over time. The participants work closely with the sector in programme design and review, standard setting, and assessment and have current knowledge of sector priorities and how it is changing.

### 10.1 TARGETED PROGRAMMES

Workplace training is arranged across six different areas for qualifications from level 2 to level 6. For this project, the following programmes are being reviewed in terms of the changes in skills and the effective delivery of these qualifications.

- Health Care Assistance and Support Work strands of the NZ Certificate in Health and Wellbeing (Level 3)
- Mental Health and Addiction Support Apprenticeship (Level 4)
- Community Facilitation Apprenticeships (Level 4)
- NZC Cleaning L3

- Diploma in Health and Wellbeing (Applied Practice) (Level 5).



## 11 CHANGING SKILL DEMANDS AND IMPACT

There are many examples of core skills for the programmes being targeted. These were discussed in depth at each workshop and categorised.

### 11.1 SKILL ACCELERATION

- Leadership
- Infection control
- Suicide prevention
- Impact of isolation on clients
- Ability to observe and report change.
- Keeping connected
- Risk management
- Communication skills
- Effective multi-mode communication
- Self-care
- Digital and technology maturity

### 11.2 SITUATIONAL DEMAND

- Cyber safety
- Ability to identify and act on risks.
- Phone support skills
- Healthy online relationships

- Adaptability for new skills
- Greater awareness of risk
- Dealing with ambiguity and uncertainty
- Dealing with challenging conversations
- Managing Chronic conditions
- Psychology first aid
- Impact of isolation on self and clients
- Ethics

### 11.3 SKILLS BALANCE

- Managing acute conditions
- Ethics
- Managing chronic conditions
- Dementia
- Clinical tasks

The changes in these skills impact all levels of qualification and all trainees and apprentices. As such, no single or uniform method of delivery will be suitable.

### PRE-POST SKILL QUADRANT ANALYSIS

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The programmes of industry training build on the technical skills and knowledge apprentices and trainees may already have and goes further to develop their critical thinking, reflective practice and expand their 'toolkit'. These skills are changing and becoming more critical.

The skills below illustrate the initial analysis from internal experts of how the importance and balance of core interchangeable skills are expected to change over the next 12-18 months.

This analysis illustrates the overarching impact of COVID-19 on these skills for all programmes being reviewed. Interestingly, it was agreed that the change in these skills are relevant and will impact trainees, apprentices, and existing staff. This highlights a growing need in the market to address and refresh these skills and an opportunity for the TITO/WDC to deepen its value to the healthcare sector.

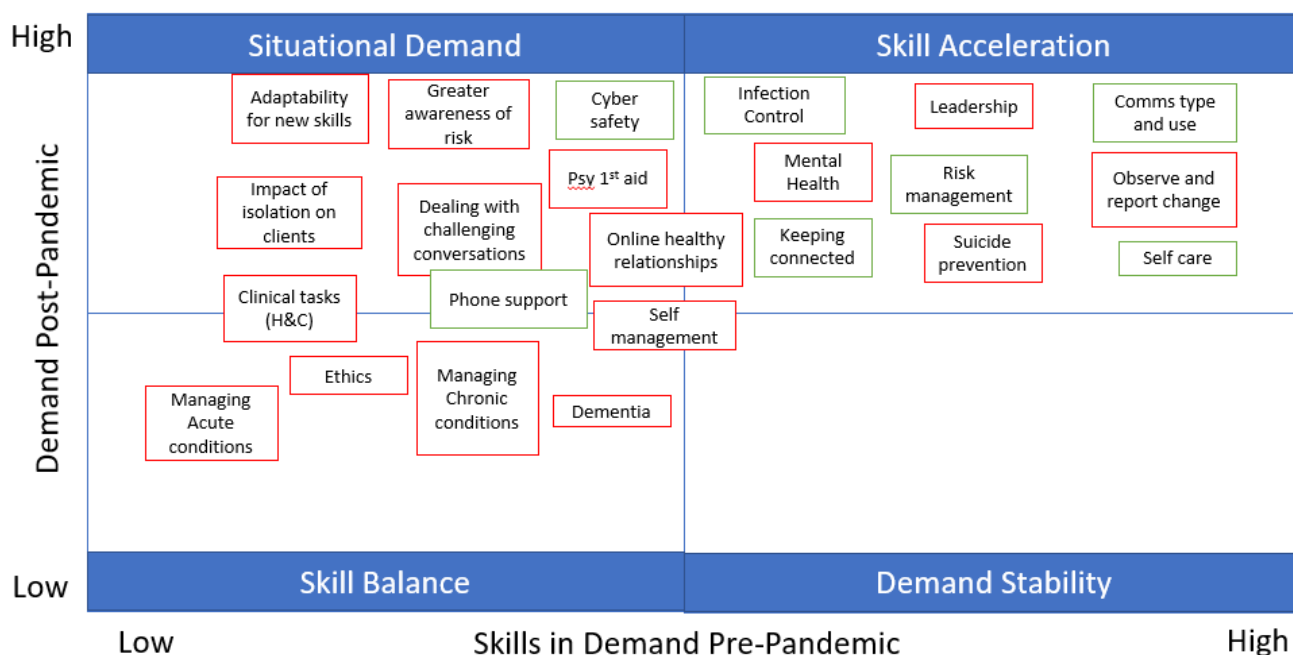


Figure showing expected changes in the demand and importance of skills in health and wellbeing sector services by Careerforce.

## 12 JUST-BEFORE-TIME DEMAND

With the changeable and ambiguous nature of the impact of COVID-19 on employer processes, systems, policy, and regulation obligations etc. any training and upskilling will need to be as agile, flexible, and adaptable as the demand requires. Rather than 'just-in-time' training, the TITO/WDC should strive to be 'just-before-time'; anticipating and driving the awareness of the improvements to be made. Any content will need to be relevant and iterative with constant refresh.

The ability to apply an agile-based process over the constant updating of content will require greater collaboration and partnership with industry, trainees, and other stakeholders. This will likely affect some features of the current roles and responsibilities of TITO staff and expertise. For example, the role of the Assessor is regarded as somewhat separate to training and upskilling. This may need to include ongoing facilitation of upskilling and training for target areas.

All medical and allied health professionals need to continue their education throughout their career to provide the highest possible level of patient care, advance their career and maintain membership in professional organisations, and more.

Doctors and nurses must complete a minimum amount of continued medical education. New research, technology, medication, and treatment pathways etc. are constant. As such, they are required to maintain their knowledge and skill base.

Some comments from internal stakeholders highlighted that their apprentices have completed their training and the focus is now on the practical application of those skills in the workplace. Whilst ongoing assessment in the workplace is required, it was also agreed that there were aspects of the workplace environment that have changed considerably in the last year. Areas such as the use of

PPE, infection control and the ability to communicate and connect remotely with clients have altered.

Therefore, given the changing nature of role and responsibilities at all levels in healthcare it would be prudent to apply something similar to the framework of continued medical education to the Kaiāwhina and Kaimanaaki workforces, providing access to smaller packets of knowledge and training and enable multiple modes of acquisition.

## 12.1 MICRO-CREDENTIALING

Skills and knowledge moving into either 'skill demand' or 'skill acceleration' will impact experienced staff as well as apprentices and trainees. The requirement to upskill and adapt does not start and end with those people directly under the TITO umbrella. Many of these skills can be isolated and developed quickly to meet the need of the market.

Given that these skills will also be part of a module or qualification, then these smaller micro-credentials could be stackable or stand-alone. The future of this project could also consider investigating the viability and value of an agile-based micro-credentialing approach.

Additional to this will be the discussion with industry partners and other stakeholders to establish scale, urgency, and awareness.

Workplace Advisors will work with employers to determine which skills are changing and how best to ensure their trainees are working towards these new skills as well as the qualifications they are working towards.

The goal will be to focus on relevant skills and knowledge in the short to medium term whilst divesting or redesigning skills that are no longer relevant to their workplace.

Together, we'll develop a comprehensive training plan and discuss steps to set up your training. We will also guide you through funding opportunities to support the growth of your employees.

This will require further investigation and clever design.

## 12.2 CONTINUED HEALTH INDUSTRY EDUCATION AND TRAINING

Continuing medical education (CME) consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession.

The content of CME is that body of knowledge and skills generally recognised and accepted by the profession as within the discipline of clinical medicine, and the provision of health care to the public.

This is a broad definition to encompass the continuing educational activities that assist doctors and nurses in carrying out their professional responsibilities more effectively and efficiently.

Continued education and training enable people in the medical field to maintain competence and learn about new and developing areas of their field. In CME, these activities may take place as live events, written publications, online programs, audio, video, or other electronic media.

However, they all point towards the same goal. The person undergoing the training and education can choose which mode and method of training they want to undertake for a particular topic.



Content for these programs is developed, reviewed, and delivered by faculty who are experts in their individual clinical areas.

It allows a practitioner to learn and discover viable ways to improve on the patient care they deliver and effectively manage a career in the ever-changing landscape of the medical industry in a manner and method that suits their personal-style and environment situation.

The requirements or acceptable level of CME vary across medical disciplines, but they are equally important no matter the specialty or scope of practice in which a provider is engaged.

The potential to adopt a similar long-term view on the continued education and training for Kaiāwhina or Kaimanaaki workforce employees means employers can:

- Refine staff skills to improve overall patient care and operational effectiveness.
- Stay current with the ongoing and rapid changes occurring post COVID-19.
- Address real-world challenges that they will be facing day to day.
- Gain professional and experiential growth and a means to advance career status.
- Meet government policy and obligation requirements.
- Reduce risk and cost.
- Become aware and learn effective new skills before they are needed.

For a continued training and education program to be viable in meeting and qualification and credentialing requirements, the framework of all programmes must be linked and accredited.

Note that “enabling ongoing professional and interprofessional development opportunities” is a key activity within Priority 5.1 of the Kaiāwhina Workforce Action Plan 2020 – 2025. There is the potential for recommendations from this project to connect to and accelerate that activity.

## 13 MULTIPLE MODES OF DELIVERY

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Most of the learning by apprentices and trainees undertaking qualifications through industry training occurs in the work environment.

The employer-led training model has been built on quality and sustainability with training embedded in everyday workplace activities. Employers support trainees to learn on-the-job and assessment is primarily carried out by assessors within the workplace.

The mode of delivery for programmes of training is by majority a combination of paper-based workbooks for supporting acquisition of underpinning knowledge; and coaching and mentoring of practical skills within the workplace, generally by a supervisor or staff member with responsibility for training.

Online learning support materials and assessments are available for most programmes of industry training, however the majority of workplaces default to paper-based resources and assessment.

Apprenticeship programmes are supported by resources and assessments provided online only. The apprentice and their workplace can access these as required. Pastoral care and assessment are provided by Careerforce Apprenticeship Advisors. There is no option to print resources should an apprentice or their workplace wish to do so.

There is no off-job directed training or modularised specialist training offered by third parties in either the programmes of training or apprenticeships. There is an opportunity to enable trainees and

apprentices to become more resilient and adaptable in their own career by making different options and modes of delivery accessible for the same module. A workplace or trainee/apprentice will be able to choose which mode of delivery and learning suits them best based according to their own situation and learning preference.

### 13.1 TRAINING DELIVERY METHODS: CHOOSING THE RIGHT MODALITY FOR CONTENT AND ENVIRONMENT

Relevant content will be a huge focus in the new world post-COVID-19, though it is really only one part of the training and learning equation. The magic happens when strong and relevant content is shared through the most effective delivery methods that are flexible enough to adapt and enable the messages to be absorbed, retained, and implemented by trainees.

There are different methods of training delivery to choose from and these need to be incorporated as real options for each trainee or apprentice based on their own situation, preference and learning style.

Traditionally, employers have preferred a paper-based system to support training and assessment of trainees. Anecdotally, this is selected because it is what they understand, can control, and are used to. However, these organisations may not have explored other modes, or have considered the most optimal mode of delivery for their context.

A paper-based system may not be the best mode of delivery for everyone. This form of delivery cannot change quickly, is less interactive than e-learning and does not necessarily engage the trainee.

There is no silver bullet but there are different options. Data continues to prove a blended approach, incorporating more than one modality to deliver content and skills, increases engagement and retention by up to 60%.<sup>34</sup>

### 13.2 DELIVERY METHODS FOR SHARPENING SKILLS & BEHAVIOURS

Moving further into training for skills, the examples of delivery methods below will allow a deeper focus on the tactical responsibilities of delivery.

These modes of delivery also lend themselves to training for behaviours, educating learners on the action taken as well as developing a greater understanding of what and how they prefer to learn. These may include group participation, hands-on activities, role plays, on-the-floor training, mentor shadowing. Each of these training delivery methods differs in their approach but share the same goal:

- To allow trainees and apprentices to improve their skills and knowledge in settings and situations where they use them.
- To develop skills and knowledge that will be relevant to the work environment as it continues post-COVID-19.

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<sup>3</sup> <https://unboxedtechnology.com/training-delivery-methods/#:~:text=In%20fact%2C%20data%20continues%20to,retention%20by%20up%20to%2060%25.>

<sup>4</sup> [https://www.accenture.com/t20160119t105855\\_w\\_us-en/acnmedia/pdf-5/accenture-digital-learning-report-and-how-to-guide\\_full.pdf](https://www.accenture.com/t20160119t105855_w_us-en/acnmedia/pdf-5/accenture-digital-learning-report-and-how-to-guide_full.pdf)

Additional to a paper-based option, there should be a focus on how, when, and where to develop the following methods.

### 13.2.1 Instructor-led Training (ILT)

Instructor-led training, or classroom training, the most traditional form of training, is best leveraged for creating an overall understanding of the training topic.

ILT is the training modality most preferred by learners, with 55% of learners reporting a preference for this method<sup>5</sup>. A key advantage of ILT is interactivity. Trainees can ask questions and receive instant responses.

### 13.2.2 Virtual Classrooms

Technology has propelled the use of virtual classrooms whether on ZOOM, Teams etc. Virtual classrooms enable employers to deliver training in different forms (text, video, and documents) in real time.

Training can be delivered from anywhere, and trainees can attend the session from wherever they are located. This saves time. Good virtual trainers can still offer a human touch. Economies of scale can be achieved with no dedicated venue when trainees are geographically dispersed. This requires good support available to the trainer and the learners.

### 13.2.3 E-Learning

E-learning is one of the most popular forms of training delivery available today. It has moved on from 'reading behind glass' and research suggests the global e-learning market is set to reach over \$300 billion in value by 2025<sup>6</sup>. 77% of U.S.-based organisations use e-learning in some form<sup>7</sup>.

Well-designed online e-learning programs can improve engagement and interaction with a mix of text audio and video; discussion forums; and/or interactive assessment.

E-learning offers flexible learning opportunities in a short time frame to a dispersed audience by delivering interactive and engaging training programs in the form of games, videos, HTML, quizzes, and other content.

### 13.2.4 Mobile Learning

According to Towards Maturity<sup>8</sup>, 64% of learners say that using a mobile device to access training content is "essential/very useful," and 89% of smartphone users download apps for learning or productivity.

Mobile learning, although a relatively new training delivery method, is increasingly offered due to the host of benefits it offers, including the ability to deliver training anytime, anywhere and on any device and in the form of microlearning, short how-to videos, social learning and other engaging formats. These best suits the needs of the in-work trainee.

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<sup>5</sup> <https://www.bizlibrary.com/blog/learning-methods/learning-preferences/>

<sup>6</sup> <https://www.globenewswire.com/news-release/2019/03/06/1748554/0/en/E-Learning-Market-to-surpass-300bn-by-2025-Global-Market-Insights-Inc.html#:~:text=The%20e%2Dlearning%20market%20is,growth%20over%20the%20coming%20years.>

<sup>7</sup> <https://elearningindustry.com/online-learning-statistics-and-trends>

<sup>8</sup> <https://learningnews.com/learning-companies/towards-maturity>

### 13.2.5 Blended Learning

With blended learning, trainees and employers can leverage a combination of approaches to ensure that the trainee utilised the method of delivery and information that is best for them.

A blended learning approach is a good option in an environment of greater disruption and change.

Over the past decade, training delivery methods have evolved with advancements in technology. One size no longer has to fit all. The same skills, knowledge and content can be delivered in a variety of ways for the same modules to different trainees.

## 13.3 TRAINING DELIVERY METHODS FOR IMPROVING KNOWLEDGE & SKILLS

Building on this further, there are several modes of delivery that bridge both knowledge and skills, helping trainees to understand the how behind the what and the why. This category includes:

- Interactive Learning Guides

Self-paced and fully interactive, Interactive Learning Guides (ILG) keep learners engaged throughout the training journey. With a modern, web-like interface, video, animation, gamification, and interactive exercises, ILGs create an engaging experience for trainees, making them effective for both knowledge and skills training.

- Videos, VLOGS etc.

Taking cues from what many trainees engage in on their own time, training and information videos are an incredibly popular choice to help them improve their skills in addition to reinforcing their knowledge.

- Simulation and Virtual and Augmented Reality Training

Simulation is a generic term that refers to an artificial representation of a real-world process to achieve educational goals through experiential learning. Simulation based medical education is defined as any educational activity that utilises simulation aides to replicate clinical scenarios.

For doctors and nurse's medical simulation allows the acquisition of clinical skills through deliberate practice rather than an apprentice style of learning. Simulation tools serve as an alternative to real patients.

As with medical staff, a health care worker or trainee can make mistakes. The advantage of simulation is they can learn in a safe environment without the fear of harming the patient.

There are different types and classification of simulators and their cost vary according to the degree of their resemblance to the reality, or 'fidelity'. Simulation-based learning can be expensive.

Effective simulation training has been found to enhance skill and competence in health care staff<sup>9</sup>. It has also been found to have many advantages that can improve skill acquisition, creative problem solving, patient safety and reduce risks through improvement of competencies.

New doctors, nurses, and other staff members can become familiar and comfortable with a variety of simulation and situations through VR. The immersive feeling and required focus of being in a VR headset are very important. According to University of Maryland researchers, trainees can increase retention of information by nearly 9% using VR over traditional video.

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<sup>9</sup> <https://www.healthysimulation.com/18769/vr-healthcare-training/>

- Gamification

Gamification is being used in organisations these days to train and develop skills and knowledge in their employees. Gamification started off as a digital learning trend but soon made it known that it was an effective learning technique that helped learners absorb and retain knowledge while keeping them engaged. Gamification works for many product and service-based industries and this includes healthcare training.

Gamification is being used by healthcare organisations to train their employees. Many healthcare organisations are hesitant to implement gamification in their workplace because healthcare is a 'serious industry' that deals with saving people's lives.

These are four reasons gamification works for healthcare training.<sup>10</sup>

- Connects with learners on an emotional level.
- Uses failure as a learning tool.
- Contains engaging activities.
- Tracks progress and offers immediate feedback

Healthcare is a slow-moving and cautious industry, especially when it comes to how it trains healthcare support workers. There its hesitation to understand and embrace relatively newer modes of blended and digital learning strategies and methods.

No one single method will satisfy all the needs, individual approaches and employer acceptance or endorsement. Like gamification and other methods, these are all ways in which healthcare workers can effectively learn, train and develop in a way that suits their own style, preferences and personal situation.

## 14 THE APPLICATION BLENDED LEARNING IN HEALTHCARE TRAINING

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Blended learning in this context is considered as a single training and educational activity designed for the same trainee or learner that is available and delivered via multiple formats from the same content or skill acquisition.

It should not matter where you access or acquire the knowledge, skills and experience to train and develop in one's role and career. It is more important that a trainee has the opportunity to demonstrate the acquisition, retention and performance of skills required in their workplace; especially in a post-COVID-19 environment where there are many changes occurring.

Blended learning activities tend to be delivered in two or more of the following formats.

- Live interaction and courses
- Enduring and fixed materials
- Healthcare based information, processes, and readings (e.g. case studies)
- Skill demonstration, performance, and improvement
- Point of care interaction and follow up.

Even though blended learning is often associated with the education sector, the opportunities, and benefits of using this concept for work-place applied training, is significant.

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<sup>10</sup> <https://elearningindustry.com/gamification-work-for-healthcare-training>

Blended learning or “hybrid learning” represents a learning model that combines multiple methods of knowledge and skill acquisition both formal and non-formal to guide and enable the trainee to navigate along the ‘corridor of learning’.

Blended learning represents a model that integrates practical, personal and technology to boost learning and deliver business impact. There are many doors into a room of training and upskilling with each door signifying a different method through which the required knowledge and skill was acquired. In today’s world, it’s the ability to demonstrate the required knowledge and skill effectively that’s critical rather than the way in which the individual obtained it.

A structured blended learning framework will consolidate all content which will improve training costs, ROI and maintain one source of relevance.

Blended learning is feasible and, with a few caveats, is an acceptable option for healthcare training. This is timely, given the ongoing changes and requirements in developing and refining skills and knowledge post-COVID-19 and that self-directed, virtual, and online learning with limited face-to-face contact is likely to become the norm in the on-going COVID-19 pandemic.

#### 14.1.1 Increase Peer Engagement

The combination of multimedia and instructional design makes the perfect recipe for a rich training and learning experience. Trainees and Apprentices are not learning in isolation and the benefits of training with peers in a team is well documented.

Analysis of the activity of trainees to monitor where they are excelling and where they are struggling is important in nudging them along their corridor of learning. This means that the content can be easily updated and optimised accordingly.

### 14.2 THE USE OF BLENDED LEARNING IN CME - THE PERCEPTION OF GP TRAINERS<sup>11</sup>

In a recent study on the experience and factors influencing the usefulness and logistics of blended learning for learners in CME, 170 GP trainers used blended learning who were undertaking a Continuing Medical Education (CME) course in evidence-based medicine (EBM).

The GP trainers found the design and the educational method attractive, instructive, and complementary. Factors influencing their learning were design, delivery method, topic of the intervention, time (planning and intervention, personal learning style, technical issues, and level of difficulty).

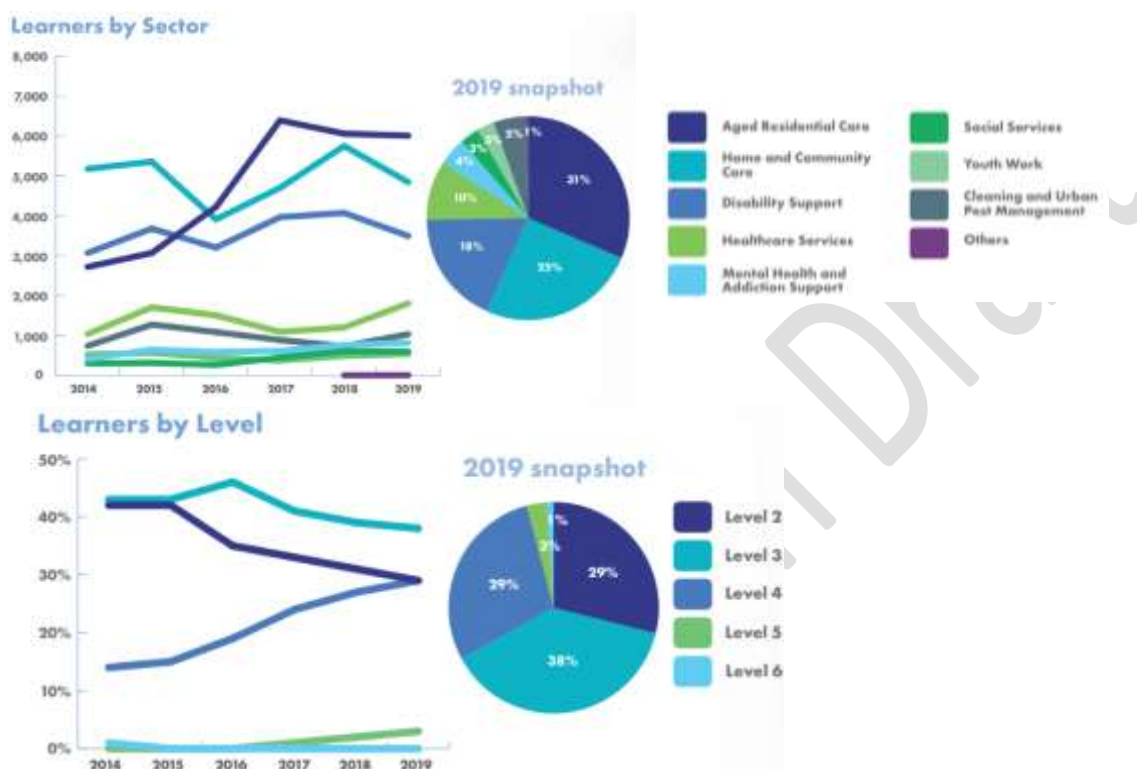
They were positive about blended learning: they found e-learning a useful way to gain knowledge and the interaction a pleasant way of transferring the knowledge into practical application.

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<sup>11</sup> <https://pubmed.ncbi.nlm.nih.gov/27012724/>

## 15 THE TYPICAL WORKPLACE TRAINEE OR APPRENTICE IN HEALTHCARE

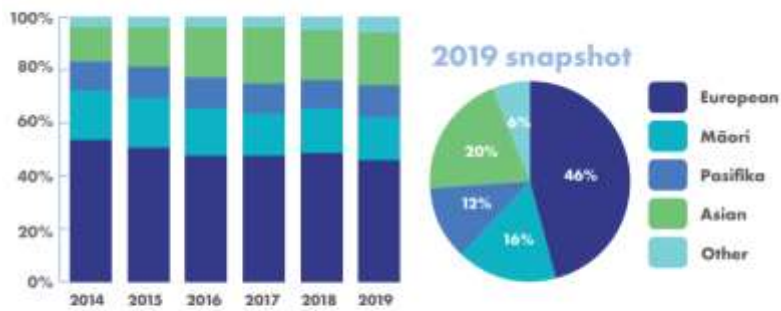
Based on insights from industry leaders and TITO staff, trainees and apprentices working in aged care, home and community and disability support account for 72% of all trainees and apprentices. Therefore, that is where the initial focus for change to mode should occur. Additionally, 67% of trainees are completing Level 2 or 3 qualifications.



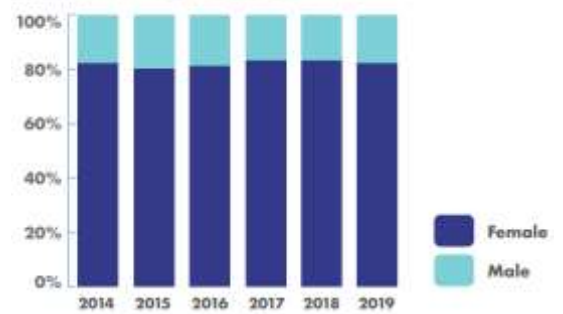
Learner demographic snapshot - Careerforce 2020 annual report.

Over 80% of workers are female and 67% are over the age of 35. Those over 55 account for 21%. These demographics will have a profound effect on the approach and methods used for training and development for them to achieve their qualifications.

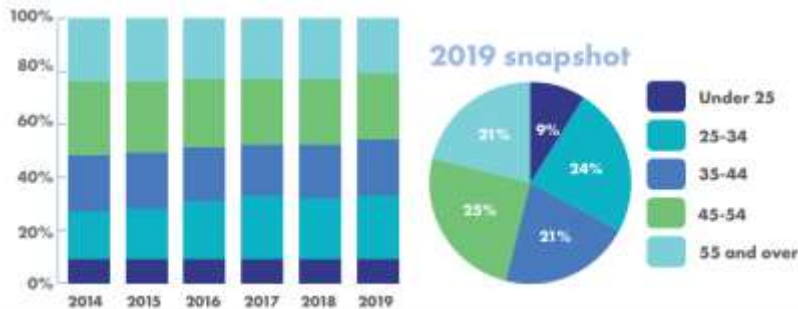
### Learners by Ethnicity



### Learners by Gender



### Learners by Age



Learner demographic snapshot - Careerforce 2020 annual report.

## 15.1 PREFERENCE AND FUTURE

The most adaptable and flexible medium for effective implementation is through blended learning. Trainees and apprentices are encouraged by the opportunity and ability to manage their own development in a structured manner, the flexibility of learning at their own pace and having resources that are linked to their workplace.

Some remain comfortable with paper-based resources because, given the average age of this cohort of trainees, that is what they are familiar with or it is the mode their employer has provided.

The opportunity to delve into the material and have access to all resources from day one was appealing as was the potential of changing the methods of delivery and training available should they choose to do so e.g. move from paper-based to online.

Blended Learning combines multiple approaches to training and learning, including virtual and physical resources. This would typically integrate e-learning, problem-based and distance learning with more conventional coaching sessions and some traditional or more rigid approaches to training if available. A blended learning approach enables trainees to have greater control and ownership over when and where training takes place. It allows the learning to be built around their work and lifestyle commitments.

Interestingly, for many of these trainees, this is the first time they have worked towards a new qualification for many years – if ever. Some of their training will need to incorporate learning how to learn in a way that suits their style, timeline, and lifestyle.



For employers a blended approach that incorporates the practical application of learning with self-produced evidence is appealing as it can enable greater transfer of knowledge from training into work practice<sup>12</sup>.

## 16 ACTION NEEDED

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### 16.1 SCALE OF CHANGE AND URGENCY NEEDED

Even before COVID-19, developments in technologies, patient preferences, and operating models were affecting the workforce. This was especially the case for clinical staff but not as prevalent for healthcare workers such as health care assistants, caregivers, support workers, orderlies etc. However, these critical staff members interact with patients.

The virus has accelerated and intensified the need for change in training, upskilling and development. It is forcing leaders to shift their organisation's traditional operations and training while fundamentally reimagining strategies and operating models.

As leaders adapt and manage their organisation through COVID-19 recovery, they would do well to identify and address weaknesses and develop their people across digital, cognitive, social, and emotional, and adaptability and resilience skills, as follows:

#### 16.1.1 Expand the ability to operate in a fully digital environment.

A degree of technological skill will be essential to each employee. Basic digital skills will enable them to feel comfortable and maintain seamless contact with patients, partners, suppliers, and public authorities<sup>13</sup>.

#### 16.1.2 Further develop cognitive skills for redesign and innovation

The new environment poses challenges requiring enhanced problem-solving skills, creativity, and innovation. The increase in remote work and development of new approaches and processes etc. requires employees to develop and demonstrate these skills in an increasingly autonomous environment.

What skills will a home support worker or someone in orderly services now need to refine or rethink how they approach their patients? Creativity? Innovation? Problem-solving? An ability to change and adapt remotely?

#### 16.1.3 Strengthen social and emotional skills to ensure effective collaboration, performance, and self-expression.

Employees need to develop communication and interpersonal skills, including empathy within a new context, in order to maintain strong ties with colleagues, patients and managers and create and grow relationships, adapt to change, and support patients with less direct contact.

#### 16.1.4 Build adaptability and resilience to thrive during COVID-19 aftershocks and beyond.

For employees to use today's new experiences and changes as a source of learning, they need support to build self-awareness, self-confidence, and self-reliance.

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<sup>12</sup> Eraut, M 2004, '*Transfer of knowledge between education and workplace settings*', in H Rainbird, A Fuller & A Munro (eds), *Workplace learning in context*, Routledge, London, pp.201–221.

<sup>13</sup> See, for example NZHIT, *Hauora, Mauri Ora: Enabling a Healthier Aoteroa*, New Zealand, Auckland, New Zealand, (2021).

Key areas to reinforce resilience include developing their ability to manage time, work within boundaries, and manage their own mental wellness. For example, a home care support worker in a community setting needs adaptability and resilience skills to modify their approach and interactions with their clients and reduce risk.

## 17 INDUSTRY SECTOR ENGAGEMENT AND CHANGE

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With the passing of the Education (Vocational Education and Training Reform) Amendment Bill which came into effect on 1 April 2020 Careerforce has moved from an Industry Training Organisation to a Transitional Industry Training Organisation (TITO).

As a TITO, the focus for the next eighteen months is to continue to enable the outcomes of trainees, apprentices, and their employers. This requires a range of ways of working and delivering services to stakeholders in order to align with their operating model and needs.

Across the healthcare sector there is variation of content and method of delivery due to the variety of employer needs. Some employers undertake training in a way which tends to reflect their traditional methods and internal process rather than the learner's preference, experience or learning style. The relationship with the TITO is more vendor based rather than a partnership.

Other organisations are far more engaged directly with the TITO. They utilise them as the expert and as a strategic partner in terms of the development and training of their trainees and apprentices.

Feedback from trainees and assessors highlight a common issue where assessments are seen as overly complicated or prescriptive, tend to take a lot of time and to focus too much on the finer details. This is the case with other work-based learning programmes such as nursing of mental health.

The variety of quality in delivery methods, content, and engagement means that there is a risk of inequity of access to relevant and consistent training. Even though the qualification may be the same, the quality of the experience can be very different.

## 18 WORK BASED LEARNING AND BLENDED-LEARNING

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The idea that work can provide a suitable context for learning is deeply rooted in experiential learning theory.<sup>14</sup>

While the benefits of work-based learning have been identified, there has been less development and attention paid to the mechanisms by which these positive outcomes are realised.

The assumption is that knowledge transfer and skill development take place automatically as trainees move through the work setting. The pedagogical strategies in place for many organisations in healthcare currently are traditional and have not fundamentally changed in terms of modes of delivery, content, or adaptability.

A trainee-centred model recognizes that there is potential value in a variety and availability of different learning assets. From this perspective, the 'blend' is more complex than just paper-based, online or in-person. The rich variety of mediated experiences provided by open training resources,

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<sup>14</sup> <https://files.eric.ed.gov/fulltext/EJ1067509.pdf>

combined with the face-to-face interactions, coaching, assessments, both formal and informal, provide a range of opportunities to reinforce new knowledge, new skill acquisition, and practical application, as well as assessment, mentoring, coaching, and support.

The best use of blended learning in the workplace effectively integrates all trainee experiences to achieve instructional goals, rather than supplementing old models of instruction with new technologies.

Although it is critical, employee training can be overwhelming and cumbersome for all the parties involved. One of the toughest obstacles is getting employees to engage and complete the training provided.

Work-based learning has the potential to transform health care services to improve patients' experiences, support the implementation of new processes, approaches, improve productivity and achieve continued evolution of an adaptable workforce.

The main aims and objectives of the work-based blended learning approaches are:

- To provide those in the healthcare workplace, wishing or needing to attain a qualification, the opportunity to attain a NZQA qualification, and to do so in a flexible cost-effective manner.
- The establishment of a collaborative workplace–training solution to identify their upskilling needs and to develop programmes flexible enough to meet these needs.
- The development of flexible delivery and support for trainees in employment using a 'blended approach' integrating choices of delivery in content and structure and in the workplace, e-learning, mentoring, and coaching.
- The integration of work-based credit-earning learning into programmes, defined by training agreements – jointly supervised and assessed by workplace and education organisation staff.

## 19 RECOMMENDATIONS

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We know that COVID-19 changed the way we live and work. It has had the largest impact on the way we live and work since World War II.

What we still don't know is how the subsequent health and economic crises will evolve over the next few years, what mindset changes will arise, what new regulations, processes and approaches will evolve, and how this will affect our healthcare environment.

One thing is certain, however: to emerge successfully from the current crisis, healthcare organisations will need to continue to nurture and develop their employees' skills to match the requirements with digital, cognitive, social, emotional, and adaptability and resilience skill sets.

The recommendations below are based on several viewpoints.

- The changing environment post-COVID-19
- Ongoing impact on the workplace in healthcare
- The tempo of changes and refinement in skills, knowledge, and systems
- Opportunities for trainees and apprentices to learn in an evolving environment.
- Leveraging and scaling the work already done with digital and online resources.
- Build multiple and interchangeable channels and models of learning.

- Be the expert and catalyst for change in blended learning and the iterative development of content.

## 19.1 ENVIRONMENT RECOMMENDATIONS

### 19.1.1 What has changed or is changing?

How has the role of the healthcare worker changed as a consequence of COVID-19? A deeper audit of training needs and relevance should be completed.

### 19.1.2 Accurately qualify and quantify the changes and impacts on the environment post-COVID for healthcare workers.

All stakeholders were able to talk about and expand on the areas that have changed in terms of skills, knowledge, process etc. over the last year following COVID-19. These have been anecdotal and top of mind.

Internal and external stakeholders have highlighted many examples where what trainees and apprentices are being asked to do is changing. Many of the processes, systems and skills required in a role have changed as a direct consequence of COVID-19.

Trainees have provided examples of where they have had to 'just deal with it' when things change, or they find themselves in a situation they are not prepared for. Some have dealt with it proactively; others have found it stressful.

A lot of these changes are common across different roles and sectors and they affect the balance of skills and knowledge required from trainees (e.g., the use of PPE and infection control). However, each sector and role will also be experiencing changes in their specific specialist area (e.g., the need to develop remote communication and technology skills using ZOOM or Messenger for home care clients). The list of small and large changes is long and each of these may or may not be captured effectively in the current curriculum and content.

## 19.2 TRAINING METHODOLOGIES AND MATERIAL RECOMMENDATIONS

### 19.2.1 Agree what skills are new, need updating or are now irrelevant?

Complete a detailed view of the impact of what is changing will inform which core and specific unit standards need to be recalibrated to reflect these changes.

For example, in a remote setting, how would a trainee communicate effectively in a culturally appropriate manner to support a person's health or wellbeing when access is limited, or they must maintain social distancing? What new communication and technology-based skills will have to be developed and assessed to achieve this part of a graduate profile in a way that is relevant to the new environment?

### 19.2.2 Identify and actively address skills and knowledge that are changing.

Many employers have their own system set up to induct and train their new workers. They tend to want to use their own methods and the majority prefer the use of a paper-based training and assessment system.

However, the half-life of knowledge and skill is decaying quicker than ever before meaning that an employer driven programme of training that is delivered in a single mode will drive inequity in

training quality and access as well as compromise the engagement and motivation of trainees and apprentices to complete their training.

As a TITO, Careerforce has always worked closely with stakeholders and employers across their sectors to identify workforce skill requirements and standards. They are responsible for developing nationally recognised qualifications (New Zealand Certificates or Diplomas). Although regular reviews occur, these have mainly been in the context of current delivery models and pre-COVID-19 paradigms. A deep audit and review will need to be conducted to ensure that training structures meet the evolving needs of the workforce.

### 19.2.3 Develop a blended learning model for employers and employees that suits different learning styles<sup>15</sup>

Blended learning has a large influence on training and learning effectiveness in comparison with groups that can only use one nonblended method. Blended learning is more effective than nonblended learning, including both traditional paper-based, face-to-face learning and pure e-learning.

The reasons for this include.

- Compared with traditional learning, blended learning allows trainees to review digital materials as often as necessary and at their own pace, which likely enhances learning performance.
- Compared with just e-learning, trainees with access to blended learning resources are less likely to experience feelings of isolation or reduced interest in the subject matter.

Any level of heterogeneity needs to be identified and avoided. Much of this may be due to variations in study design across different modes of access and employers, assessment design being over complicated, places of work, and type of participants.

### 19.2.4 Develop cross-organisation trainee networks.

One way to encourage consistency and continuity of training is to develop trainee networks from different organisations. By doing so, groups of different trainees can collaborate and learn from each other. Blended learning would also allow for peer-to-peer assessment, joint problem-based learning, and a shared pressure to complete their qualification. This is also where the equivalent of CME for healthcare support workers can be developed.

### 19.2.5 Foster a culture of collaborative and continuous learning

Learning is more effective, and retention is higher, when trainees take on the role of both the learner AND the teacher. This enables them to absorb and demonstrate their best skills, and learn from others in a more informal, stress-free environment.

Partnering with other trainees either in their organisation or from another company will allow them to exchange invaluable knowledge, share experiences, and trade the key healthcare tips you can only learn from experience.

These collaborative discussions also play a positive role during performance and assessor evaluations. Collaborative learning is critical in an environment of flux and change. In a study, 87%

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<sup>15</sup> Liu Q, Peng W, Zhang F, Hu R, Li Y, Yan W The Effectiveness of Blended Learning in Health Professions: Systematic Review and Meta-Analysis J Med Internet Res 2016;18(1):e2 doi: [10.2196/jmir.4807](https://doi.org/10.2196/jmir.4807)

said sharing knowledge with their peers or team is “very important” or “essential” to learning in the workplace<sup>16</sup>.

When studying adult workplace learning, it was found<sup>17</sup> that curiosity and proactive engagement was directly related to training by increasing information-seeking activities and connecting the doing with the learning, creative thinking and problem solving. Curiosity is related to progress, effort, purpose commitment and enjoyment in the pursuit.

#### 19.2.6 Introduce Social Influence

Curiosity is also contagious. As a group, trainees asking more open-ended, thought and idea-provoking questions will generate interaction and the number of ideas people and teams generate on a distinct upslope. Any collaborative platforms used to engage trainees should focus on getting them to ask more ‘what if’ questions and explore ideas and concepts.

#### 19.2.7 Use, invest and develop online learning platform(s) further

As e-learning continues to grow and develop, the timing is right to further invest in platform(s) to become the core learning and assessment resource rather than the existing paper-based versions still preferred and used by many employers.

The development of smart and simplified bespoke assessment activity types will also enable the management of multiple attempts of an assessment more easily.

Trainees and apprentices will continue to benefit from automated and fully responsive learning resources, making it much easier for e-learning users to fit learning into their day, on any device.

The ability to collect and provide real on-the-job evidence from workplace observers using the e-learning platform will assist assessors to make sound judgements from authentic work practice as it happens.

#### 19.2.8 Make all training materials accessible 24/7

Provide employee training material, resources and exercises that are completely open and available 24/7, and mobile device friendly. This will enable trainees to develop their skills, test themselves and provide evidence when they have the opportunity.

#### 19.2.9 Drive and develop micro-learning assessed via stackable micro-credentials for high change, high demand areas

As we navigate a world disrupted by COVID-19, opportunities to quickly learn new skills have never been more important.

Micro-learning provides access to a wide range of education and training opportunities, allowing people to re-skill for a new career, or up-skill in their existing one. It is designed to be flexible, so people can learn in a way that suits their individual needs and circumstances.

Micro-credentials certify the achievement of a specific set of skills and knowledge. Smaller than qualifications, they focus on areas not currently met in the tertiary education system that meet a need from employers, industry, iwi, or the community. Learners can achieve micro-credentials in the workplace, classroom, online or through a blend of these options.

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<sup>16</sup> Bersin, J (2013) *Learning in the Workplace*, Deloitte, New York.

<sup>17</sup> Reio, T. G., & Wiswell, A. (2000). Field investigation of the relationship among adult curiosity, workplace learning, and job performance. *Human Resource Development Quarterly*, 11, 5-30. doi:10.1002/1532-1096(200021)11:1<5

From an employer's perspective, micro-credentials can respond to industry needs more quickly than qualifications, which take longer to develop before learning commences. They allow New Zealand businesses the opportunity to partner with tertiary education organisations, responding quickly to critical knowledge and skill gaps.<sup>18</sup>

### 19.3 EMPLOYER RECOMMENDATIONS

Even though employers are not necessarily the instructional or subject matter experts, workplace training tends to be employer-led. The employer is responsible for the delivery of training, and assessment of employees.

Employers and their employees access support services, including workforce development planning, the provision of learning and assessment resources, and pastoral care to support apprentice and trainee success.

The quality, consistency and relevance of training materials and delivery structure varies significantly across different organisations. Some utilise the expertise and resources provided whereas others utilise their own training programmes and resources.

#### 19.3.1 Be the expert and anticipate.

Education organisations have the depth of knowledge and expertise to determine, design and develop learning and assessment resources that satisfy the needs of the trainees, address the ongoing changes in skills and knowledge and encourage equity of quality, consistency, and applicability. Employers can contribute to the development through providing subject matter expertise and articulating priority or emerging areas where a skill(s) response is required.

#### 19.3.2 Creating a supportive learning culture

The main purpose of trainees and apprentices is to work, learn and grow. It is a sound investment to allow trainees to spend time on learning activities which will reap long-term benefits by up-skilling and motivating their staff. A training culture needs to permeate all levels in the organisation so that trainees are comfortable learning and working, and that colleagues do not regard them as less productive in doing so.

There is a risk that employees do not always have the time or resources available to train, and many rely on employees training occurring in their own time away from work. This means that on-demand access to different resources at all times can enable trainees to balance and connect learning with work.

On-job training programmes have been developed that recognise knowledge and skills that apprentices, and trainees, may already have. Currently workplace training is mainly employer-led, where the employer is responsible for the delivery of training, and assessment of employees who are enrolled in programmes.

Under this model there is third party support to employers and their employees, including workforce development planning, the provision of learning and assessment resources, and pastoral care to support trainee success.

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<sup>18</sup> The-value-of-micro-credentials, NZQA, retrieved Mar 2021 <https://www.nzqa.govt.nz/>

However, in the current changing environment there is a risk of inequity in training due to employers not having the expertise or resources to develop new training frameworks or a learning culture in response to the change.

### 19.3.3 Developing Supportive learning cultures

Many employers have processes for inducting and training staff that do not necessarily consider the learning needs of their employees and are delivered using a 'one size fits all' method.

Employers can draw on expertise provide by third parties to support their induction and training and to provide content that trainees can use and reuse.

Modern learners want training modules that are media-rich, interactive, and social-enabled. Provide a mix of media to address various learning styles trainees prefer. Allow them to rate, share, and discuss experiences, challenges, and content. This will drive engagement and participation, while also helping employers identify which employees have leadership skills. Trainees should be able to access (or be assigned) modules that address their skill gaps, add to their competencies, or prepare them for future roles.

### 19.3.4 Make learning experiential for Employers.

Experiential learning is a well-established concept in healthcare education and refers to learning occurring when experience is reflected upon. When it comes to practicing what is learned or just studying printed material, retention of information older than two weeks more than doubles with practice (68% compared to 29%).

The four components of experiential learning that assessors and mentors can guide trainees through as part of a blended learning environment.<sup>19</sup>

- Concrete experience: Active involvement in the experience
- Reflective observations: Analysing the experience.
- Abstract conceptualisation: Drawing conclusions and evaluating what the trainee has learned.
- Active experimentation: Implementing what has been learned.

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<sup>19</sup> Psychologist David Kolb, a pioneer in the field of experiential learning