Care and Support in the Community Setting

Health Workforce Advisory Committee
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CONTENTS

EXECUTIVE SUMMARY iv

1. BACKGROUND 7

1.1 Introduction 7

1.2 Policy and legislative environment 8

1.3 Definition of the support workforce 10

2. THE QUALITY AND SAFETY PROJECT 12

2.1 Overview 12

2.2 Background 13

2.3 Findings 13

2.4 Factors affecting the limited availability of the workforce 18

2.5 Conclusions of the Quality and Safety Project Report 20

3. PROGRESS SINCE THE QUALITY AND SAFETY PROJECT 23

3.1 Working towards a mandatory home-based support sector standard 23

3.2 Improving training of support workers 25

3.3 Barriers to training for home-based care 27

3.4 Reviewing the effectiveness of Ageing in Place initiatives 28

3.5 Reviewing the home-based support services purchase model 29

3.6 Improving information collection and analysis, and communication within the sector 31

4. CONCLUSIONS 32

5. RECOMMENDATIONS 33

REFERENCES AND BIBLIOGRAPHY 42

EXECUTIVE SUMMARY

Support services are a vital part of daily life for many New Zealanders with lifelong disabilities, and for older New Zealanders. Quality support services in the community enable these people to make positive choices about their lifestyle, to participate fully in society, and to pursue their personal aspirations. As New Zealand's population continues to age, the Government has committed to a programme of developing services that provide an integrated continuum of care to ensure that older people feel safe and secure, and can 'age in place' in their own homes.

Achieving these objectives is crucially dependent on having a stable, well-trained and committed support workforce. In 2001 the Aged Care Forum (convened by Hon Ruth Dyson, Associate Minister of Health, as an advisory group to the Implementation of the Health of Older People Strategy) raised concerns about the quality and safety of support services across residential, home and community settings. They identified the state of the support workforce as a major part of this issue.

In response to these concerns, the Ministry of Health was tasked with scoping the extent of quality and safety issues in the support services sector, including the specific aspects of the workforce that were generating these issues. The Quality and Safety Project, running from September 2003 to December 2004, was the first major piece of work to examine emerging issues about the workforce development needs of the support workforce in residential and home-based service settings, for lifelong disability support and services for older people.

The Quality and Safety Project identified a number of safety concerns in both residential and home-based care, but found that the higher risks were in the home-based sector. The key issues were:

- the existence of service gaps created by significant problems recruiting and retaining support workers
- inadequate training
- support workers in home-based services working in isolation with minimal orientation, training and ongoing supervision.

Support co-ordinators interviewed highlighted that in their view support workers resigned due to a lack of pay, not enough guaranteed work hours and uncertainty about a career path.

The Quality and Safety Project team identified three factors contributing to safety issues within the support services sector (primarily with the home-based sector):

- the lack of a mandatory standard for home-based services
- inadequate training for workers delivering personal care services
- the lack of flexibility in the current fee-for-service purchasing model within home-based services.

Some work was already in progress within the Ministry of Health on these issues, including a review of home-based services. Work is currently being undertaken to assess provider readiness for the implementation of NZS 8158: Home and Community Support Sector Standard. Over the past two years there has been a strong effort from home-based support providers to work towards incorporating the requirements of this standard into purchase agreements.

A joint project between the Ministry of Health and the Community Support Services Industry Training Organisation (CSSITO), the Home Based Support Services Training Initiative, is looking at piloting the implementation of a National Certificate in Community Support Services

(Foundation Skills) Level 1. A staircase of qualifications for support workers has been developed by CSSITO, fitting into the New Zealand Qualifications Framework.

Since 2004, work on the priorities identified in the Quality and Safety Project has been progressed by the Ministry of Health, Accident Compensation Corporation, District Health Boards (DHBs), CSSITO and support services providers. It is the extent of this progress that the Health Workforce Advisory Committee (HWAC) has sought to examine in *Care and Support in the Community Setting*, to trace activity occurring across the sector and to highlight the gaps still needing attention.

This paper, *Care and Support in the Community Setting,* considers the non-regulated support workforce that delivers services in the community. The focus continues to be on both residential and home-based support workers delivering lifelong disability support services and services for older people. The scope and timeframe do not allow this project to consider mental health support workers.

To inform its recommendations, HWAC invited sector representatives to a discussion day on 9 June 2006 (the June forum). Participants at the forum stressed the development of home-based support services as a continuing priority. A high level of consensus was reached among support services providers, CSSITO, DHBs and other funders on the progress achieved so far, and the way forward. The idea behind the forum was to devote a day specifically to training, organisational development and systems development, so consumers were not invited, but they were consulted through wide dissemination of the discussion document.

A common concern has been the lack of flexibility in the current fee-for-service purchasing model for home-based services. In response to such concerns, new approaches to funding and service delivery that co-ordinate 'packages of care' for older New Zealanders are currently being evaluated. Preliminary results show a package-of-care funding model supports the view held by many providers that a national shift to this style of purchasing could result in significant improvements for service users and a reduction in the high rate of turnover of support workers.

It is HWAC's view that progress on the priorities identified in the Quality and Safety Project represent steps towards stabilising care and support services in the community, and the development of this sector as an industry that attracts a committed and skilled workforce. While important activity is under way, providers continue to voice strong concern that without further significant investment, support services in the community will continue to be plagued by poor retention of staff and associated quality and safety issues for service users.

HWAC acknowledges the committed efforts of many organisations to improve service delivery and employment practices, but recognises that progress towards what are now well-accepted directions for the development of sustainable support services continues to be hampered by a purchase model that does not give providers adequate scope to advance organisational and workforce development.

The vision of safe and high-quality care and support in the community setting has not changed. The goals of the Quality and Safety Project looking towards a mandatory home-based sector standard, compulsory training for support workers providing personal care services, and a shift towards a package-of-care-oriented purchase model remain.

The sector is strongly committed to these goals and has a strong desire for increased collaboration to get there. However, two years after the Quality and Safety Project it is clear that only further investment – resourcing the sector to bridge the gap between current practice and these desired outcomes – will result in the level of workforce development required for stable and sustainable service delivery.

Recommendations

To this end HWAC recommends that:

1. purchasing of home-based support services moves from the predominant ‘per hour, per client’ funding model to a ‘packages of care’ model, to enable providers to guarantee support workers set hours of work and to have greater flexibility in facilitating training and supervision

2. findings from the Assessment of Services Promoting Independence and Recovery in Elders (ASPIRE) trial inform the development of service specifications for home-based support services for older people

3. Home and Community Support Sector Standard NZS8158:2003 be made mandatory by 2008, with extra funding provided for implementation, compliance and audit

4. increased funding should be phased in, contingent on providers having an ongoing orientation, training and development package for all staff – this could be achieved through contractual changes over time

5. the emerging career framework for the support workforce be formalised to include competencies linked with the New Zealand Qualifications Framework

6. the Ministry of Health be invited to provide leadership and oversight for the continuing development of the support workforce.

1. BACKGROUND

1.1 Introduction

The Health Workforce Advisory Committee (HWAC) has been tasked with preparing advice for the Minister of Health on measures to develop the care and support workforce. This workforce needs to be developed to ensure the delivery of quality future care and support services in the community, and, in particular, lifelong disability support services and services for older people.

The need for action on this workforce arises from several drivers, including:

- recognition that the process of population ageing will significantly increase demand for care and support services for older New Zealanders
- an understanding that the level of quality and safety of services continues to be a prominent issue for the sector
- in some service areas – particularly those for people with intellectual disabilities, physical disabilities and intellectual disabilities requiring compulsory care – providers are experiencing difficulties recruiting sufficient numbers of support workers.

In response to pressure on the older people's services sector, the Government has provided significant increases in funding during the 2004/05 and 2005/06 financial years. The 2006 Budget provides $126 million over the next four years towards improving home-based support services and residential care for older New Zealanders; this comprises $58 million for home-based support services and $68 million for residential care. The increase is on top of the $39.5 million Future Funding Track and demographic pressures funding provided for the wider older persons' services sector for 2006/07.

The Ministry of Health's Disability Services Directorate has also received budget increases for support services. The budget increases for the 2006/07 financial year are $18 million for residential care services and $7.3 million for home-based support.

Project approach

This paper uses the Quality and Safety Project (QSP) as its foundation. Although some progress has been made, there is more work to do to address that report's recommendations, which is where *Care and Support in the Community Setting* picks up. Recognising the breadth of initiatives currently under way to progress development of the support sector for both lifelong disability support services and services for older people, HWAC invited sector representatives to a discussion day to help inform our thinking. (The attendees at this meeting are listed in Appendix 1).

The discussion on HWAC's Care and Support in the Community Setting project was held on 9 June 2006 (the June forum) with the following objectives:

- to share activities currently occurring across the sector
- to develop a picture of the challenges that are being well addressed and the gaps still needing attention
- for the sector to identify concrete priorities for investment and action to be communicated to the Minister.

The outcomes of this meeting have informed the development of the recommendations contained in this paper. A consultation document was sent out to the sector in late June 2006 and 41 submissions were received, which helped to inform this final version of the paper. (The submitters are listed in Appendix 2).

1.2 Policy and legislative environment

The direction for lifelong disability support services and services for older people in New Zealand is set out in several government strategies published since 2001. The overarching theme of each of these strategies is that support services should, as far as possible, be provided in the community context and that service users be supported to make positive decisions about options for living and care.

There is a confusing array of terms used to describe services provided to people with lifelong disabilities, older people and those requiring care because of an accident. In this paper the term 'support services' will be used to cover the whole ambit of this sector.

Support services are funded by three separate mechanisms, as follows.

- The Disability Services Directorate of the Ministry of Health funds services provided to people requiring lifelong disability support.
- District Health Boards (DHBs) fund services for older people.
- ACC funds social rehabilitation services for claimants eligible under the Injury Prevention, Rehabilitation and Compensation Act 2001.

However, it must be noted that the Disability Services Directorate budget is less than the DHB funding for services for older people due to the size of the population receiving services.

It is also important to note that the term 'support services' covers an extremely diverse range of services and scale of providers. The needs of service users and the skills required to deliver appropriate services vary between people with a lifelong disability and older people, but there are also significant overlaps. The strategies outlined below reflect the differing emphasis between a *social model* of disability and a tendency towards a *clinical support model* for older people, which recognises that the ageing process often requires health services intervention. Strategies encompassing people with lifelong disabilities and older people have the vision of a more inclusive society, eliminating the barriers to participating in and contributing to society through providing support to make life and care decisions.

New Zealand Disability Strategy

The New Zealand Disability Strategy released in 2001 sets out a vision for a society that values the lives of people with disabilities and continually enhances the full participation of people with disabilities in society (Minister for Disability Issues 2001). The key direction of this strategy with regard to home-based support services is to ensure the support workforce is skilled to deliver home help and personal care in a way that reflects the values and attitudes of the strategy. Some of the relevant objectives from the Disability Strategy are to:

- create long-term support systems centred on the individual
- support quality living in the community for disabled people
- support lifestyle choices, recreation and culture for disabled people.

Positive Ageing Strategy

The New Zealand Positive Ageing Strategy was released by the Minister for Senior Citizens on 10 April 2001 (Ministry of Social Policy 2001). The Office for Senior Citizens developed the strategy in consultation with a range of older people's expert and advisory groups, key sector organisations, individuals, and communities of interest from all over New Zealand.

The purpose of the strategy is to promote positive ageing across a broad range of sectors, and to improve opportunities for older people to participate in the community in ways they choose. The strategy identifies policy principles for positive ageing, priority goals and key actions, and is used in policy planning by central, regional and local government agencies.

Goal 2 of the strategy is to ensure 'equitable, timely, affordable and accessible health services for older people'. This includes developing health service options that allow the integrated planning, funding and delivery of primary, secondary, residential care and community support services. Goal 5 is to ensure that 'older people feel safe and secure and can age in place' (ie, in their own homes). This follows an international agreement in 1994 by OECD social policy ministers to develop policy initiatives that support older people to 'age in place'.

Government departments undertake work to contribute to the goals and to advance the key actions of the strategy. Their contributions are co-ordinated through annual Positive Ageing Action Plans and are monitored by the Office for Senior Citizens.

Health of Older People Strategy

The Ministry of Health's policy framework for health sector action to 2010 to support the health and independence goals of the Positive Ageing Strategy is set out in the Health of Older People Strategy (Associate Minister of Health and Minister for Disability Issues 2002). Both the Ministry of Health and DHBs have responsibility for implementing the eight objectives (see box below) and the associated action steps of the strategy.

Health of Older People Strategy objectives

1. Older people, their families and whānau are able to make well-informed choices about options for healthy living, health care and/or disability support needs.
2. Policy and service planning will support quality health and disability support programmes integrated around the needs of older people.
3. Funding and service delivery will promote timely access to quality integrated health and disability support services for older people, family, whānau and carers.
4. The health and disability support needs of older Māori and their whānau will be met by appropriate, integrated health care and disability support services.
5. Population-based health initiatives and programmes will promote health and wellbeing in older age.
6. Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning.
7. Admission to general hospital services will be integrated with any community-based care and support that an older person requires
8. Older people with high and complex health and disability support needs will have access to flexible, timely and co-ordinated services and living options that take account of family and whānau carer needs.

In October 2003 the Government devolved responsibility for funding support services for older people from the Ministry of Health to DHBs. The aim was to provide greater integration of support services with other health services at the local level, and to provide for a holistic focus on the total health needs of older people.

The key principle underlying the Health of Older People Strategy is the development of an *integrated continuum of care approach,* paraphrased below:

> *an integrated approach to health and disability support services that is responsive to older people's varied and changing needs. Providers co-ordinate their services, working closely with the older person and, where appropriate, with their family, whānau and carers to provide services that appear seamless to the recipients. For Māori operating within a framework of whānau ora, this means placing the whānau at the centre of health care and support for older Māori.*
> (Associate Minister of Health and Minister for Disability Issues 2002 p3).

An older person should be able to access the services they need at the right time, in the right place and from the right provider. The goal is that older people receive support services so that they can age in place as long as possible, and have access to higher-level supportive care if and when it is needed.

Each DHB is required to outline in its annual plan the progress it has made towards the development of this approach. The integrated continuum of care programme for older people is expected to be implemented nationwide by 2010.

1.3 Definition of the support workforce

Support workers deliver a wide range of services to clients requiring lifelong disability support or older people, in residential facilities or private homes, based on individualised support plans. Services range from household management (eg, helping with basic domestic tasks such as cleaning) or personal care (eg, showering, bathing and toileting), through to administering medication and advanced personal care. Support workers also help people to continue participating in their community, such as using public transport, accessing day programmes and through advocacy. Some support workers work alongside rehabilitation professionals, assisting with implementing rehabilitation plans (Ministry of Health 2004). Support workers specifically helping people with lifelong disabilities deliver services that include behaviour support programmes, supporting development of independence and life skills, and relationship and community presence.

The support workforce is therefore a diverse group, providing services in a range of settings and for a broad spectrum of needs. As a result this is a challenging workforce to define. The QSP and District Health Boards New Zealand (DHBNZ) use slightly different definitions of the disability support workforce. Because this project took into account this work while developing its own definitions, the differing versions are outlined below.

Quality and Safety Project

The *Quality and Safety Project* (Ministry of Health 2004) defined a disability support worker as 'an individual who, under full or part time (or other) employment agreement with a provider, delivers the disability support services defined in the project scope'. A full list of the inclusions and exclusions is given in Appendix 3, but briefly the QSP focused on:

- Vote Health–funded services, such as home-based disability support and community-based physical and intellectual disability support services
- long-term residential support
- respite support
- ACC-funded services.

Some of the main exclusions were unregistered diversional therapists, palliative care, and unregistered workers in the hospital setting and mental health support settings.

District Health Boards New Zealand

DHBNZ's Non-regulated Workforce Strategy Group (WSG) included the following definition of the non-regulated health workforce in their draft report, *The Non Regulated Workforce in the Health, Disability and Mental Health Sectors*: the non-regulated workforce (paid/unpaid) includes all workers not regulated by the Health Practitioners Competence Assurance Act 2003 who interact directly in the care of people in the health and disability sector, including people with: chronic disease, disabilities, mental illness or older people (Acqumen 2006).

The WSG classified the range of non-regulated roles into the following four strategic categories, relating to the broad work, service and funding streams:

- inpatient hospital services
- residential
- community supports
- needs assessment and service co-ordination (see Appendix 4 for details).

The definitions for this document

This Care and Support in the Community Setting Project builds on the work of the QSP, examines initiatives in the sector and works in tandem with DHBNZ's paper. We have defined support workers and support services as follows.

- *Support workforce:* the paid workforce that delivers services in the community in both residential and home-based settings, providing support services to people with lifelong disabilities and older people.
- *Support services:* all health and disability support services provided to people with lifelong disabilities and older people, such as household management and personal care, access to the community, and development of skills for living and independence

The QSP made a distinction between younger disabled people and older people. This report aims to bring these groups together and make the distinction not in terms of age but between people requiring lifelong disability support services and older people requiring support services. Although these two service areas have differences, this paper will highlight both the alignments and significant overlaps.

2. THE QUALITY AND SAFETY PROJECT

2.1 Overview

In 2001 the Aged Care Forum was convened by Hon Ruth Dyson, Associate Minister of Health, as a sector advisory group on the implementation of the Health of Older People Strategy. The forum identified the quality of support services across residential, home care and community services as a fundamental issue, and the state of the support workforce as a significant contributor to this.

The Ministry of Health was tasked with scoping the extent of quality and safety problems in the support services sector, including the specific workforce issues that were generating these problems. The QSP, running from September 2003 to December 2004, was the first major piece of work to examine emerging issues relating to the workforce development needs of the support workforce, and factors causing poor rates of recruitment and retention.

A variety of data collection methods were used, including extensive research undertaken by Auckland UniServices under contract to the Ministry of Health. This research included quantitative and qualitative surveys, and interviews and focus groups with providers, support workers and clients (a list of the sector reference groups is included in Appendix 5).

The QSP is the most up-to-date research on the support work sector, and by completing significant consumer surveys it gives a picture of service users' perspectives as well as those of providers and funders. Some of the main findings of the surveys are outlined below.

Service user surveys

A wide range of service users were interviewed as part of the QSP (Ministry of Health 2004), including older people, people with lifelong disabilities, people needing home-based care, people needing rehabilitation/habilitation support, a mix of European, Māori and Pacific people, and people from both rural and urban areas. Following are some of the main views expressed by service users.

- Turnover and lack of continuity are affecting health and safety. Turnover was viewed by respondents to be directly linked to poor pay and working conditions.
- Needs assessors place too much reliance on family members to fill gaps or supplement the services provided.
- Often service users do not feel sufficiently safe to raise concerns, fearing they might be labelled as 'difficult' by support workers or providers.
- Poor safety practices are the result of a lack of training of support workers, combined with a lack of understanding of what it is like to be disabled.
- Once services are in place there is little follow-up, and service users feel powerless to make changes.

The focus groups agreed that the following aspects would make for a quality support service:

- client-centred, flexible services with a back-up support system
- access to quality information
- appropriately trained support staff who are monitored
- funding to secure the quality support required for people with lifelong disabilities and older people to live lives of their choice in the community.

The QSP incorporated work already in progress within the Ministry, including a review of home-based services. Work to assess provider readiness for the implementation of NZS 8158: Home

and Community Support Sector Standard (see section 2.5) and the development of a Foundation Certificate for disability support workers were also undertaken as components of the QSP.

This section outlines the scope of the QSP and the core aspects of its findings on the support workforce, and describes the work that commenced to address its conclusions.

2.2 Background

Purpose and vision

The QSP's vision was to improve the health and wellbeing of those receiving services from support workers by enhancing the quality and safety of support services delivered in the community and residential care settings. The project aimed to help achieve this vision by providing recommendations to the Government on a policy and purchasing service framework for disability support services.

The recommendations were to provide a guide to Ministers on ways to address service user and workforce quality and safety issues identified in the course of the project. The recommendations were to support future support services and workforce planning to meet the needs of the support services sector.

The QSP's specific objectives were to:

- develop a definition of quality and safety
- define the determinants and identify issues of quality and safety for the population in the project scope
- define the workforce development and training requirements of this workforce to meet current and future needs
- identify the workforce needs and capabilities for both current and future services
- assess current and future organisations' capability to provide services that demonstrate appropriate quality and safety standards
- provide an information base and robust framework for future decisions that can improve service outcomes for clients.

Method

A series of four surveys of service providers (parts 1 and 2), support workers and service users were undertaken by Auckland University, on behalf of the Ministry of Health and ACC. The findings of these surveys were used to inform the recommendations of the QSP.

2.3 Findings

Current supply of support workers

The 420 service providers who responded to the QSP provider survey employed a total of 30,301 support workers in both home-based and residential care settings (Ministry of Health 2004). Extrapolation using median data figures put the estimated total of support workers employed by New Zealand support services somewhere between 40,000 and 50,000, meaning that the findings of the survey represented approximately 64 percent of all support workers (Faculty of Medicine and Health Sciences 2004a).

There are approximately 850 residential care providers, 34,000 beds and 25,000 health care assistants (residential caregivers for the elderly). It is estimated that between 18,000 to 25,000 are home support workers. Table 1 provides an estimate of the total number of support workers, by DHB.

Table 1: Estimated number of support workers, by DHB

DHB	No. of surveys sent	No. of surveys returned	No. of support workers	% of total support workers	Estimated total no. of support workers
Auckland	125	64	1984	10.2	3875
Bay of Plenty	42	28	1106	5.7	1659
Canterbury	137	76	3506	18.0	6320
Capital and Coast	59	24	584	3.0	1434
Counties Manukau	46	21	737	3.8	1614
Hawke's Bay	32	15	1020	5.2	2176
Hutt Valley	10	9	186	1.0	207
Lakes	14	5	112	0.6	314
MidCentral	44	25	944	4.8	1661
Nelson Marlborough	37	22	1492	7.7	2509
Northland	46	20	1479	7.6	3402
Otago	72	46	2333	12.0	3652
South Canterbury	10	8	322	1.7	403
Southland	21	13	676	3.5	1092
Tairawhiti	6	3	162	0.8	324
Taranaki	30	17	509	2.6	898
Unknown	23	12	246	1.3	472
Waikato	66	37	864	4.4	1541
Wairarapa	12	6	101	0.5	202
Waitemata	74	31	950	4.9	2268
West Coast	4	2	34	0.2	68
Whanganui	14	7	131	0.7	262
Multiple DHBs	16	16	10,714	*(not in calculation)*	10,714
		507			**47,066**

Source: Faculty of Medicine and Health Sciences 2004a

Providers responding to the QSP survey reported that the scope of services required in home-based settings was generally wider than in residential settings. They highlighted that people with high and very high needs are predominantly receiving support in residential settings. Many providers catered for a wide range of service user needs and ages and provided a mixture of home-based and residential services.

Demographics of the current workforce

Key demographics from the QSP provide the following picture of the support workforce.

- Most are female (the ratio of male to female support workers was approximately 1:16, although there were proportionally more male co-ordinators, with a ratio of 1:8).
- Most are middle-aged (62 percent of female support workers are aged over 41 years). However, male support workers tended to be slightly younger, with only 48 percent aged over 41 years).
- The ratio of Māori to non-Māori support workers is approximately 1:7.
- Employers indicate that approximately 15 percent of support workers have verbal communication difficulties in English, and that written communication difficulties are an even greater problem. The Service Provider Survey Part 1 suggests that the proportion of support workers with communication difficulties in English varies by geographical location, with Waitemata, Auckland and Counties Manukau DHBs over-represented.

Hours worked

Support workers work a median of 24 hours per week, with home-based workers working a median of just under 13 hours per week and residential workers 25 hours a week (Faculty of Medicine and Health Sciences 2004a).

Table 2: Support worker hours, by service type

	Less than 5 hours	**6–10 hours**	**11–20 hours**	**21–30 hours**	**31–40 hours**	**Over 40 hours**
Home-based	26.4%	25.4%	25.6%	11.7%	6.3%	4.6%
Residential	2.1%	7.8%	16.8%	30.7%	39.6%	3.1%
Mix of home-based and residential	8.8%	9.0%	16.4%	26.9%	31.1%	7.8%

Source: Faculty of Medicine and Health Sciences 2004a

Table 2 shows that over 50 percent of home-based workers work 10 hours or less a week. The QSP suggested that this result highlights the possibility that home-based workers may predominantly work part-time or have more than one job:

> *Co-ordinators mentioned that many of their support workers preferred to work fewer hours, or to have flexible work schedules because of family commitments or other work commitments. However, they also reported that many support workers were overworked because they held multiple jobs, or because they took extra available shifts whenever they could to earn additional money. This finding is consistent with international studies that show that many home based support workers hold more than one job and work full-time hours without the benefits associated with full-time status* (Crown et al 1995; Yamada 2002) (Auckland Uni Services 2004a).

It is also possible that a proportion of the support workforce relies on government income support and limits their hours to avoid reducing eligibility to this, although further analysis would be required to see whether this is a significant factor in the part-time employment trend of support workers. Figures from Bay of Plenty DHB show that nearly 60 per cent of support workers are beneficiaries in that area.

One programme aimed at addressing both workforce recruitment and retention and assistance packages to enter the workforce has come up with an innovative plan. Hawke's Bay DHB, together with the Ministry of Social Development, is running a programme to help women previously on the Domestic Purposes Benefit to train as support workers. Caregivers are paid while training and work on both the National Certificate in Community Support Services (Foundation Skills) Level 1 and National Certificate in Support of the Older Person NZQA Level 3. After training, the women are guaranteed 30 hours per week work. There are future career pathway options open to them now, and participants are looking at co-ordinator roles and even starting nurse training.

Casual employment agreements

There appears to be a strong reliance on casual working arrangements throughout the support services sector. Home-based support workers are more likely to be employed part-time or on a casual basis than residential workers.

Retention

Support worker turnover per annum is high (39 percent in home-based services, 29 percent in residential care and 22 percent for mixed services).

Training

Approximately 83 percent of the support workforce have no recognised support worker qualification. The following numbers are estimated from the QSP provider survey. From an estimated total of 46,856 support workers:

- 7967 (17 percent) are already qualified
- 38,899 (83 percent) have no recognised qualification:

Table 3: Support workers with no recognised qualification and estimated numbers of home support workers providing personal care, by support setting*

	Total support workers	**% of total support workers**	**Providing personal care**
Already qualified	**7967**	**17**	
No recognised qualification	**38,899**	**83**	
Home support only	7033	15	3516
Home support & residential care	15,292	33	7646
Residential care only	16,574	35	
Number providing personal care			11,162

* Based on an assumption of a 50:50 split for home support workers between personal care and household management (Faculty of Medicine and Health Sciences 2004a).

Although most providers reported having a training programme, these programmes varied across the sector. Opportunities for, and attendance at, training were significantly higher in residential than in home-based services. Different training approaches were seen as being necessary for home-based and residential care services (Ministry of Health 2004).

Funding of training and giving staff time off for training were seen as the biggest barriers in an environment where effective training is becoming increasingly essential. While less than half of providers reported not having adequately trained support workers, almost half of new support workers did not receive orientation before they saw a client. This situation was significantly exacerbated by high staff turnover.

All providers recognised the importance of training to ensure safe and quality service delivery, but many faced difficulties ensuring adequate and appropriate training is given due to funding constraints, high turnover, the diverse needs of clients and poor readiness for training among the workforce.

Cultural competency

Home-based providers reported that they employed larger numbers of Māori support workers than did residential providers, but there were few Māori co-ordinators. The ratio of Māori to non-Māori was approximately 1:7 for support workers in home-based services, which is comparable to the population as a whole (Ministry of Health 2004).

Providers who employ Māori support workers were asked to comment on whether appropriate procedures and protocols are observed to maintain the cultural safety of the workers. Forty percent of both home-based and residential providers reported that such procedures were in place for Māori staff. Cultural safety was one area of training that all providers believed to be important, although one of the barriers to training identified was lack of culturally appropriate educators.

One Māori co-ordinator stated that Māori support workers did not perceive any reason to be trained if they were supporting whānau.

A support unit for Māori and Pacific support workers and service users was suggested, to provide a central information point, advocacy services and interpreters in the various Pacific languages.

Pay

The QSP found that wage rates were low (in home-based services take-home pay was sometimes less than the minimum wage once non-reimbursed travel costs were taken into account). The report's findings, indicating 2004 wage rates, are given in Table 4.

Table 4: Wage ranges for staff, 2004

	No. of responses	From $ per hour	To $ per hour	Median wage
Home-based support service workers				
• home help/household management	112	$9.96	$11.17	$10.00
• personal care	114	$10.31	$11.84	$10.82
• care for client with high needs	87	$11.03	$12.64	$11.00
Residential service support workers	325	$10.35	$12.56	$11.00
Co-ordinator standard day rate	308	$16.49	$18.92	$18.00
Co-ordinator standard night rate	95	$15.96	$18.35	$18.00
Co-ordinator on call night rate	69	$14.86	$21.23	$16.00

Source: Adapted from Faculty of Medicine and Health Sciences 2004a

The report found that:

> *A significant number of the home based support workers undertook part-time work and travelled for over an hour a day, which did not tend to get paid. If travel time and cost is taken into account, the hourly rate for home based support workers is reduced significantly. (Faculty of Medicine and Health Sciences 2004a p36)*

In response to the findings of the QSP, the Government has increased funding for home-based and residential care services during the 2004/05 and 2005/06 years. Estimated figures from the Ministry of Health for the 2005/06 year show that there has been an increase in the median wage for both home-based 'help/household management carers' from $10, as shown in the above table, to $10.53 per hour. For home-based personal care the rate has increased from $10.82 to $11.53 per hour.

Reimbursement for expenses

The QSP provider survey found that reimbursement for travel costs (travelling time, vehicle expenses and public transport) was more prevalent in the home-based service types, but by no means occurred all the time. As Table 5 shows, of the home-based support services providers who responded to the QSP surveys, only about half reimbursed support workers for costs relating to the use of their own vehicle. Clothing and uniform expenses were reimbursed more in the residential setting than in the home-based setting (57.3 percent vs 19.6 percent).

Table 5: Reimbursement for support worker expenses, by service type

	Home-based reimbursed	% of home based (n = 51)	Residential reimbursed	% of residential (n = 232)	Mix of home based and residential reimbursed	% of mixed (n = 119)
Travelling time	10	19.6	12	5.2	13	11.4
Own vehicle expenses	26	51.0	32	13.8	37	32.5
Public transport	6	11.8	11	4.7	10	8.8
Clothing/uniforms	10	19.6	133	57.3	71	62.3

Source: Faculty of Medicine and Health Sciences 2004a

The QSP stated:

> *Given that a significant number of providers do not reimburse travel time or costs, a median 20km per day on average is a highly significant cost to the individual especially when considering the (estimated) $7500.00 home based support worker annual salary. (Faculty of Medicine and Health Sciences 2004a p39)*

The QSP concluded that home-based support workers were generally disadvantaged compared to residential support workers, receiving lower wages, incurring significant work-related travel expenses, and receiving less training.

Travel cost reimbursement 2004–06

In the 2005 budget $18.6 million (GST exclusive) was provided for home-based support services for improving employee pay and conditions, and $3.1 million was used to sustain the December 2005 6 percent price increase for services funded through the Disability Services Directorate. The additional $15.5 million was used to encourage providers to develop travel cost reimbursement policies.

Consistent with the employer's role in setting employees' terms and conditions, providers took the responsibility for designing policies that would work given their business conditions. The pace at which this initiative has been implemented has varied across the country, but most providers have completed a travel cost reimbursement policy for their workers.

The 2006 Budget allocated an additional $22 million for home-based support services. While the specific requirements for allocating these funds have not been fully decided, the funding will be targeted at improving the sector.

2.4 Factors affecting the limited availability of the workforce

The second part of the QSP service provider survey sought to identify the reasons for the high turnover of support workers so that these issues could be addressed in future policy development. The support workforce co-ordinators interviewed felt that support workers most often resigned as a result of:

- lack of pay
- lack of guaranteed work
- lack of a career path.

Most of the providers gave examples of how support workers could find work elsewhere with higher remuneration and fixed hours. Also, the workload was less in other positions with similar pay rates.

Co-ordinators mentioned that providing care for frail people can be physically and emotionally tiring. Providers also highlighted that personal care tasks included in the support workers' role are often not pleasant. All providers could understand the reasons why the support workers left, and many accepted this as an unavoidable problem of the support service sector.

However, studies have shown that high staff turnover is not an inevitable aspect of the support services sector, but one that can be improved by minimising staff absenteeism and improving salaries (Ministry of Health 2004).

Training

Providers felt that training is important and could reduce staff turnover, but it is difficult to ascertain whether sufficient training or pressure to undertake training is related to staff-turnover. This could be examined in more depth in future studies. Research indicates that even though training is important, there are many other significant areas that should be addressed to improve staff retention. It appears that training needs to be linked with increased work autonomy and career opportunities in order to reduce turnover (Ministry of Health 2004).

Status

Lack of status and respect for the support worker position was also considered a factor contributing to high turnover. Many providers felt the public had unrealistic expectations of the service and a negative attitude towards support workers.

Competition between providers

The QSP reinforced the view that many home-based support workers leave one organisation to move to a home-based support job with a different provider. Co-ordinators in the focus groups indicated that this was the case for many of their workers. Co-ordinators in Christchurch, in particular, said that this established competition between the providers. This situation creates stress for the co-ordinators, who said they had to work hard to encourage their support workers to stay with their organisation because they were all short staffed.

Career paths and professional development

The lack of a career path for support workers was also thought to be a major factor in their turnover. Co-ordinators believed that many support workers consider the role as a temporary position and are unlikely to invest time in developing their position further:

> *Some home based co-ordinators stated that they were so desperately short-staffed that they employed anyone they could, whether that person was committed to the position or not. The providers admitted this was not the ideal situation but the reality of managing the daily demands of the service left them no choice. The coordinators also mentioned that support workers had a difficult time developing their careers because the gaps between skill levels of positions in the industry were too large. There was an understanding that some support workers would leave the industry if they wanted to develop their career or make more money. Other research has indicated that a lack of a career path or opportunities for career advancement leads to high turnover among support workers* (Ministry of Health 2004).

Co-ordinators reported high stress levels and high burnout rates in their managerial positions. Stress and burnout were listed as common reasons why co-ordinators leave their positions.

In summary, it was concluded that support workers leave the support industry as a result of inadequate pay and lack of an established career path.

Summary of Quality and Safety Project findings

Factors affecting safety include:

- service gaps
- worker and skill shortages due to high turnover
- decreased access to services
- inadequately trained workers delivering support services
- workers carrying out tasks outside their scope of practice and training
- difficulty with recruitment, especially in rural areas and areas that have other seasonal employment options
- support workers in home-based services working in isolation, with minimal orientation, limited training, and minimal monitoring and supervision
- reported abuse of clients by workers, and of workers by clients
- evidence of insufficient risk assessment and risk management in some home-based support services.
- services not currently meeting the Home and Community Support Sector Standard.

Factors affecting quality include:

- the increasing acuity and complexity of client needs, requiring workers to have increased skills
- a need to build the capacity of the Māori and Pacific peoples' support service workforce to deal with future demographic changes
- lack of a client-centred focus and lack of support for family/whānau
- lack of continuity of care due to high turnover
- lack of privacy for clients
- inflexible services, lack of responsiveness, and lack of client choice of support workers
- lack of information about services, duplication of assessment, lack of integration between support services funded by different agencies, and lack of cultural appropriateness in mainstream services.

2.5 Conclusions of the Quality and Safety Project Report

From these findings the project team identified three key areas of concern contributing to safety issues within the support services sector:

- the lack of a mandatory standard for home-based services
- inadequate training for workers delivering personal care services
- lack of flexibility in the current fee-for service purchasing model within home-based services.

These are discussed in detail below.

The lack of a mandatory standard for home-based services

In 2002 the Ministry of Health and the Accident Compensation Corporation (ACC) undertook a joint project to develop a standard for home-based support services under the Health and Disability Services (Safety) Act 2001. This standard, NZS 8158:2003 Home and Community

Support Sector Standard, was published by Standards NZ in 2003 and establishes the minimum requirements that should be attained by providers of home and community support services.

The NZS 8158:2003 Home and Community Support Sector Standard (HCSS Standard) potentially covers all Ministry of Health, DHB, ACC and privately funded providers of home-based support services. The HCSS Standard can be made mandatory either by being gazetted under the Health and Disability Services (Safety) Act 2001 or through incorporation into contracts with providers. Compliance with the HCSS Standard therefore remains voluntary for providers who do not have it incorporated in their contract.

As part of the QSP, ACC and the Ministry of Health jointly commissioned an audit of a national sample of providers to assess the gap between current practice and the HCSS Standard. Between June and November 2003 39 audits of providers of home-based services were completed. This included 29 mainstream, eight Māori, and two Pacific providers. The key findings included:

- indications that in some cases support workers are providing assistance that is not clearly defined in individual care plans, and where the support worker has not been assessed for their competency to provide that level of care
- indications that in some cases systems to determine and monitor the competency of support workers are inadequate, particularly where clients have high-level needs
- evidence of insufficient risk assessments prior to service delivery and documentation of risk management plans (Ministry of Health 2004).

This audit, and routine audits of residential care providers, highlighted that the areas most needing development are the lack of policies, procedures and quality systems – particularly in the training and supervision of staff. Twenty-five percent of providers in the 2003 audit showed high risk/critical risk findings against criteria in the HCSS Standard.

The providers involved in the audit used the findings as a tool to enable them to develop systems to implement the HCSS Standard within their work settings. An audit workbook for the HCSS Standard was also developed to allow organisations to self-assess their service in order to identify areas that require additional development prior to an external audit against the HCSS Standard. The areas of service quality most commonly identified as needing to be addressed were:

- individual care plans and client reviews
- monitoring and supervision of support workers
- understanding of the requirements for Māori
- training of staff
- organisational management.

The project also involved preliminary work on an analysis of the gap between services contracts and the HCSS Standard, and an analysis of the potential costs of implementation. The QSP team proposed that moving providers towards compliance with the HCSS Standard should be the way forward, and that this could be achieved by:

- making the requirements in the HCSS Standard part of provider contract service specifications
- assisting providers to comply by using financial incentives
- over time, moving towards incorporating the HCSS Standard into the legislative framework of the Health and Disability Services (Safety) Act 2001, which currently applies to hospitals, rest homes and community group homes.

Inadequate training for workers delivering personal care services

The QSP concluded there was clear evidence that the state of the support workforce is a significant factor affecting the quality and safety of services provided to people with lifelong disabilities and older people. The QSP identified the need for mandatory training to a basic foundation certificate level for workers delivering personal care services (such as toileting, bathing and showering). The needs of people with lifelong disabilities and older people do differ, but there are considerable overlaps and these should be acknowledged in the contracts, training and deployment of support workers.

The QSP supported work, commenced in 2002, by the Community and Social Services Industry Training Organisation (CSSITO) to develop a National Certificate in Community Support Services (Foundation Skills) Level 1 (25 credits), with the intention that this would provide the stepping-stone to a national certificate qualification (minimum 40 credits). Linked with the national certificate was the early stages of development of a staircase career pathway, whereby a framework is provided for the progression of training to higher competency levels.

The QSP team noted that although different levels of training are required to support clients with different levels of need, to ensure basic safety the first priority is that workers delivering personal care be required to complete the National Certificate before they begin to provide care. The QSP believed a route towards compulsory training could be to include requirements for nationally agreed levels of trained workers into provider contracts, or through an amendment to the HCSS Standard.

Lack of flexibility in the current fee-for service purchasing model for home-based services

The QSP found that the residential care purchase model of a set rate per bed day did not appear to be contributing to problems with the safety and quality of residential care services. However, for the home-based sector, consultation found that the lack of guaranteed ongoing work associated with the ‘per hour per client’ funding model is seen by providers as affecting the quality and safety of those services. It was believed that the purchase model contributes to staff retention and recruitment problems, and to the casualisation and inefficient utilisation of the workforce (Ministry of Health 2004). The QSP team felt that this purchase framework needed to be reviewed, incorporating a collaborative approach between ACC, the Ministry of Health, DHBs and providers.

3. PROGRESS SINCE THE QUALITY AND SAFETY PROJECT

Since 2004 work on the priorities identified in the QSP have been progressed by the Ministry of Health, ACC, DHBs, the Community and Social Services Industry Training Organisation (CSSITO) and support services providers. There has been a strong effort from home-based support providers to work towards incorporating the requirements of the HCSS Standard into purchase agreements. Progress has also been made on piloting the implementation of the National Foundation Certificate through a joint project between the Ministry of Health and CSSITO called the Home Based Support Services Training Initiative.

Work on making purchasing models more flexible has not advanced as quickly. Current purchasing frameworks (hourly basis/fee for service) do not provide the right incentives for improving people's functioning. In fact they operate perversely to boost the incentive to increase the number of hours of support provided. An alternative purchase model, bulk-funded packages of care, is being used by Presbyterian Support Otago, with positive results for staff training and organisational development. Preliminary results from Otago support the view held by many providers that a national shift to this new funding model could result in significant improvements for service users and a possible reduction of the high turnover rate of support workers.

The Assessment of Services Promoting Independence and Recovery in Elders (ASPIRE) trial, conducted by the University of Auckland, is an investigation of the effectiveness of an initiative in restorative home care. If restorative models of care are effective in restoring functional ability in older people – increasing longevity, reducing hospital admission and delaying entry into permanent aged residential care – there will be implications for funding and purchasing models.

3.1 Working towards a mandatory home-based support sector standard

Since the development of the HCSS Standard, the home-based support sector has continued to work on service improvement and risk management with the expectation that the HCSS Standard would become mandatory. Many of the larger providers have already incorporated many of the requirements of NZS 8158:2003 into their service contracts and therefore are largely ready for its imposition.

To date only Otago DHB contracts specifically require providers to comply with the HCSS Standard, however. DHB-contracted providers in Otago were expected to comply with the HCSS Standard by 1 July 2006 and, as a result, one provider in Otago decided to exit the market, citing the cost of compliance as the reason.

ACC has agreed to make a one-off payment to those of its providers who have met the HCSS Standard. This payment is based on initial audit costs and no further payments relating to meeting the HCSS Standard will be available in the future. ACC has also undertaken to work with the Ministry of Health and DHBs to address key issues facing the support services sector, including the position of the HCSS Standard.

The ongoing question has been the extent to which many other smaller providers will be able to meet certification of the HCSS Standard without additional funding to cover gaps in the areas outlined above. The view of the sector is that, as it currently stands, imposing mandatory standards without extending funding for a number of providers to meet extra requirements would result in a number exiting the market. It is therefore clear that funding needs to be allocated for the implementation of, compliance with and auditing of the HCSS Standard.

The Disability Services Directorate within the Ministry of Health has contracted Health Outcomes International (South Australia) to provide a comprehensive review of the costs, strategies and infrastructure involved in home-based support services funded by Disability Services Directorate in meeting the HCSS Standard. This review is by no means of the whole sector – just the portion funded by the Disability Services Directorate – so care will need to be taken with results that may not apply to providers of other types of support services. A final report is expected by the beginning of 2007.

Mandatory implementation of the HCSS Standard remains the next major step in ensuring the sustainability of the home-based support sector. It sets the infrastructure for growing this sector as a viable career choice for support workers, and provides a benchmark for ensuring service-user rights, sustainability, organisational processes, service planning, record keeping and supervision.

The organisational development involved in meeting a mandatory standard for the sector, and ensuring appropriate supervision, training and support for the home-based workforce represents a move towards the kind of 'healthy workplace environments' recently promoted by the Health Workforce Advisory Committee in the *National Guidelines for the Promotion of Healthy Working Environments* (HWAC 2006). In that report HWAC highlighted that ensuring work places are 'healthy' will be critical to retention of the health and disability workforce. A description of the six principles for a healthy working environment are included as Appendix 6, and represent a vision for an ideal working environment for support workers in this sector. These principles relate to:

- organisational culture
- leadership and decision-making
- change management
- information and knowledge-sharing
- career development
- employee recognition.

A number of providers at the June forum indicated a strong willingness for the HCSS Standard to become mandatory in the short to medium term, but sought financial assistance from the Government to enable providers not yet incorporating the HCSS Standard into their service contract to undertake the development required to do this.

One of the core barriers reported by providers in achieving compliance with the HCSS Standard continues to be managing high rates of staff turnover. High turnover, particularly in the first year of employment, renders it uneconomic for providers (and funders) to invest in this workforce (Capital and Coast DHB 2005). Low numbers of senior staff mean that if the HCSS Standard is imposed in the current environment, management resource that is currently fully occupied with managing high turnover rates will need to be released to conduct training and undertake the supervision requirements to maintain safety (Capital and Coast DHB 2005).

A number of providers at the June forum reported concerns that co-ordinators have increasingly high workloads and face a growing risk of burnout unless the pressure created by high turnover is eased. In the support services sector, where the providers of services to people with lifelong disabilities and to older people are often the same, many providers believe that urgent reform of the purchase model is needed to provide the capacity for growth and to curb turnover rates.

Summary of key issues

- The NZS 8158:2003 Home and Community Support Sector Standard is not yet mandatory, although many large providers report that they are already achieving compliance.
- Smaller providers require varying degrees of organisational development to meet the HCSS Standard, with most pointing to high staff turnover as a key barrier to realising the organisational capacity to undertake development in line with the HCSS Standard.
- There is an issue of whether the HCSS Standard should be made mandatory through contract or under the Health and Disability Services Safety Act 2001.
- A number of providers seek government assistance to be able to meet the requirements for certification, although a clear analysis of the gap between current practice and the HCSS Standard is not available at present.
- Extra funding will be required to meet implementation, compliance and audit costs of making the HCSS Standard mandatory.
-

3.2 Improving training of support workers

Some progress has been made in the area of training for support workers, but further work is required to ensure that New Zealand has a qualified and sustainable support services workforce. A key issue identified in the QSP was the lack of basic training for workers providing personal care services in the home.

Disability services

As a result of the QSP's findings about a lack of basic training, the Home Based Support Services Worker Training Initiative was developed for lifelong disability support workers. This was progressed by CSSITO establishing and gaining New Zealand Qualifications Authority (NZQA) approval for a National Certificate in Community Support Services (Foundation Skills) Level 1 for support workers, which requires the development of training and assessment materials, systems development and the recruitment of trainees. However, inadequate resources prevented the full national roll-out of this qualification, so with the funding available the Disability Services Directorate, in conjunction with CSSITO, began work to pilot implementation of this programme in August 2005. Disability Services Directorate has contributed $4.5 million to develop, test and implement this training initiative, and CSSITO will provide some of its Standard Training Measure funding from the Tertiary Education Commission.

In the first stage of the project, which ran from September 2005 to February 2006, home-based support services providers (funded by Disability Services Directorate) were asked to complete a self-review of 'training readiness'. Based on this information, a pilot group of support workers was selected to take part in the training initiative. It is expected that approximately 1200 support workers, working in support of people with lifelong disabilities, will be included in the trial.

In November and December 2005 a series of six road shows for those providers took place in several locations around the country to gather feedback on the proposed training plan. The trial is expected to run from March 2006 to June 2007 and will be independently evaluated to ensure the training and assessment materials and processes developed are flexible and sustainable beyond the term of the initiative. A limited amount of funding will also be set aside to help these providers become 'training ready'.

A career pathway for support workers

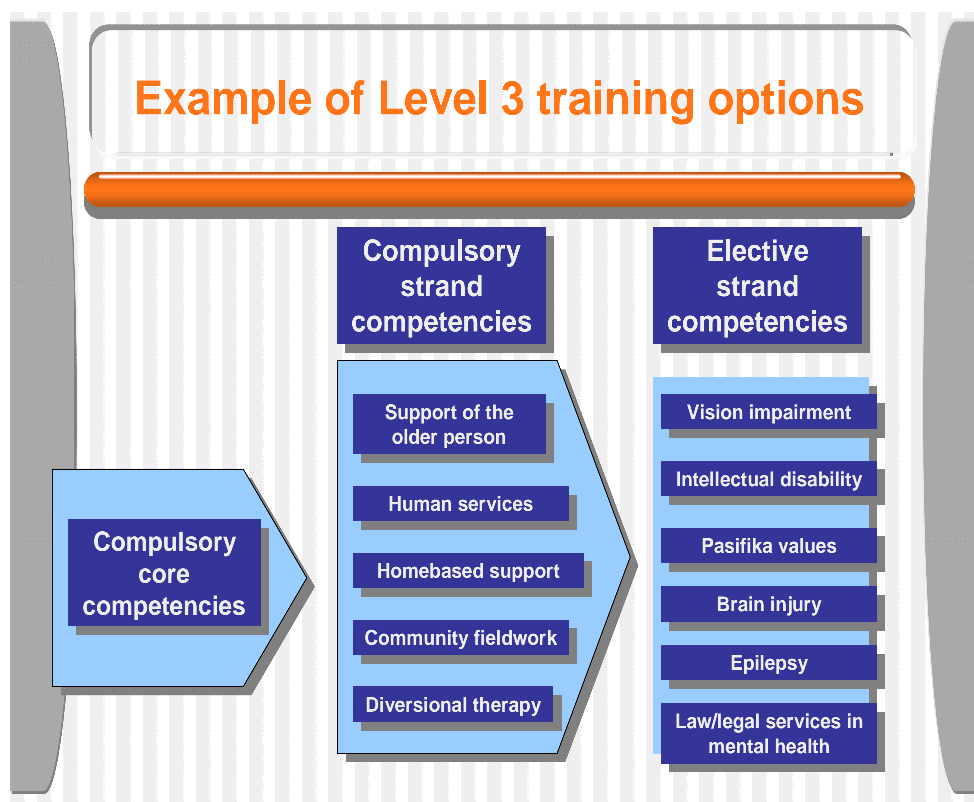
At the June forum, providers gave the overwhelming message that the lack of a structured career pathway is one of the top issues contributing to worker dissatisfaction and consequently high turnover. A qualified and competent workforce is required in the support services sector to deliver quality and sustainable care to service users. Providers agreed that all staff need to be involved in training and gaining competencies that are linked to a national qualification and the NZQA National Qualification Framework. This should then lead to minimum national qualifications being required of all support workers through contractual requirements.

For this to progress, a national career framework, or 'staircasing model', must be adopted across the health sector so that roles can be aligned to the regulated workforce and a seamless career path made available if desired. To achieve this, the sector needs to collaborate to agree on:

- service delivery models
- role requirements
- role competencies
- gap analysis of competencies that need to be developed to add to the framework
- the need to build new unit standards into the National Qualification Framework
- developing learning resources.

CSSITO has already developed a career pathway qualification with a staircased approach (see Figure 1), which applies to both lifelong disability support and the support of older people. It includes compulsory elements as well as extra optional elements, depending on a person's area of interest or client group. A joint project is being established between the Ministry of Health and DHBNZ to create a career framework for the whole health sector, and CSSITO's work will help inform the sector-wide framework. Within the overall framework, a specific project focusing on support workers is required. The training is under way, but the health sector needs to co-ordinate and develop scopes of practice for all support workers.

Figure 1: A staircased career pathway for support workers



The scopes of practice would have a wide base to include all support workers, and will include additional competencies depending on whether they are for home-based or residential, lifelong disability support or older person's support. Home-based support workers have different skills from residential-based support workers, who also have more on-site supervision. As a result, home-based support workers need to be able to work more independently, and may have to exercise judgement on a service user's condition and therefore have more responsibility. The Ministry of Health could be invited to lead this work and take it forward.

3.3 Barriers to training for home-based care

One of the main barriers to implementing training is the existing funding model. Evidence from the pilot of the Community FIRST (Flexible Integrated Rehabilitation Support Team) funding model, used by Presbyterian Support Otago, shows that a bulk-funded or package of care model enables providers to pay staff for training opportunities and staff meetings. Providers at the June forum felt that the provision of paid training would be a major breakthrough for many providers, and that this was linked to funding models. If services are purely funded on hours worked with service users, there is no time for staff meetings or training. Most providers agreed that a new funding model with bulk funding would help providers organise training for staff (see section 3.5), but all providers agreed that what was even more necessary was more funding to train staff properly.

Other barriers related to training include:

- distance from the office for rural workers to get to training
- the demographic of support workers, which is largely women aged 40–60 years with low-level educational achievement who have low confidence in their learning abilities and for whom training represents a stressful and unknown challenge (Capital and Coast DHB 2005)

- 40–50 percent turnover, leading to stressed co-ordinators whose role reverts to finding workers to cover on a day-to-day basis rather than having time to work on organisational development and staff training.
- backfilling – to provide services while staff are undertaking training
- second-language English and literacy problems

New funding models (discussed in section 3.5) will enable providers to deal with these issues in their area. These barriers to training were also highlighted in 2004 survey results (Capital and Coast DHB 2005), which show that the only training a majority of home-based support workers receive is compulsory orientation, and even this is sometimes curtailed to cover for shortages in service delivery. Apart from providing paid training, other issues that need to be addressed include encouraging workers to understand the value of training, and ensuring it fits in with workers' other jobs. As we have seen, many workers in this sector work part-time and do several jobs, so scheduling time for unpaid training is often difficult or means suffering a financial loss.

Employers need to receive incentives to embed learning, training, supervision and assessment in all workplaces for all staff. These incentives need to increase employers' sustainability and in the long term be contractually linked. It is anticipated that this new method will result in an appropriately paid, sufficiently qualified and flexible workforce. Support workers will be in careers that are attractive and can be developed, and therefore staff will be retained, giving this sector more stability. In time, contracts should become dependent on learning and development outcomes being provided in each workplace. Further down the track, preferred provider status could be conferred on providers who deliver learning and development opportunities to all staff.

Summary of key issues

- The Home Based Support Services Worker Training Initiative for lifelong disability support workers is well under way, and wider roll-out is being planned.
- Providers agree that a career framework needs to be developed, incorporating a staircased model linked to the regulated workforce to ensure people have a career path should they desire it.
- The sector's goal is that all staff need to be working towards a qualification on the National Qualifications Framework, with the proviso that in the medium to long term it is a contractual requirement of all providers to have all staff on the National Qualifications Framework.

3.4 Reviewing the effectiveness of Ageing in Place initiatives

New approaches to service delivery for older people are being investigated in the form of the University of Auckland's Assessment of Services Promoting Independence and Recovery in Elders (ASPIRE) project. ASPIRE involves funders and providers working together in three locations to implement new care arrangements, encompassing packages of care and co-ordination of services through a case management approach.

There has been an assumption that these alternative approaches to service delivery are favoured by patients, families and health care providers and are also significantly more cost-effective than residential care. However, there has been a lack of evidence for the effectiveness of such services in the New Zealand context. The ASPIRE trial was launched in 2003 to evaluate three of these pilot initiatives. The study is aimed at:

- assessing the effectiveness of Ageing in Place Initiatives (AIPI) compared with conventional home-based care
- assessing the effectiveness of AIPI in improving survival, and enhancing independence and quality of life as opposed to conventional forms of care
- determining the effects of AIPI with respect to client, family, providers and funders compared with the conventional care model
- assessing the sustainability of AIPI to improve outcomes and cost changes over time.

The services being evaluated are the:

- Presbyterian Support Community FIRST (Flexible Integrated Rehabilitation Support Team) initiative in Hamilton
- Masonic Promoting Independence Programme (PIP) in Wellington
- Coordinator of Services for the Elderly (COSE) case management initiative in Christchurch, formed as part of the Elder Care Canterbury Project.

The trials are all based on a case management model with the aim of ensuring older New Zealanders can access co-ordinated packages of care. The target group is older people or people with an age-related disability who are patients of the designated general practices. These are home-based services, although providers have developed relationships with residential service providers to facilitate transitional residential beds to help people recover to a level where they are able to return home.

The three trials have similar traits but do differ. COSE is an evolution of the current needs assessment and service co-ordination service and is based on a 'key worker' case management model. PIP also has key workers assigned to each service user, who liaise with a wide-ranging multidisciplinary team that provides holistic services. Community FIRST includes the above multidisciplinary team format, but offers a different approach by including the integration of physical activity into the day-to-day delivery of services.

Over 500 older people are in the ASPIRE trial, making it the largest study to evaluate community health care services for older New Zealanders. The trial period concluded in June 2006, and an evaluation report is due shortly. Preliminary results indicate support for the view that compared to usual care in the community, Ageing in Place initiatives improve survival and reduce admission to permanent residential care for the older person.

Key issues

- The results of ASPIRE, due to be released shortly, provide evidence that trialled Ageing in Place models have positive benefits, including: improving the lives of older people, reducing premature admission to permanent residential care and improving functioning

3.5 Reviewing the home-based support services purchase model

The QSP found that the bed-day based subsidy purchase model was working for residential care, but that there was a lack of flexibility for the home-based sector in its per hour per client funding model. With specific regard to a continuum of home-based support services for older people, the Government's aim to facilitate ageing in place requires that services strive towards a *rehabilitative* approach – one that works within a philosophy that older people can recover function – and to provide a service that encourages the older person to maintain control over his or her daily life, where possible (Capital and Coast DHB 2005). To achieve this kind of approach,

services for older New Zealanders must be flexible and able to cope with changes in the needs of service users from day to day.

Many providers report that within the limitations of the current fee for service model it is difficult to develop flexible services that are responsive to the needs of service users, and to allocate adequate resources for staff training and supervision. It is also difficult to develop and design long-term business and workforce plans.

A review of overseas purchasing models reflects a trend towards a rehabilitative model of support, and that a variety of successful approaches to purchasing are possible, depending on local circumstances. Research shows that purchasing frameworks impact directly on whether service users' changing needs can be met adequately. Evidence is emerging indicating that home-based care is cost effective if designed and delivered properly (Capital and Coast DHB 2005).

Recently established purchase models reviewed overseas incorporate a devolved budget managed through a case management system. The co-ordinators are able to organise the most appropriate packages of care according to the needs of service users and their informal caregivers, with some services able to employ staff for a guaranteed number of hours per week. Many providers attempt to ensure that service users have one specific support worker as their primary support worker. One of the major benefits arising from these bulk-funded models is an improvement in workforce recruitment and retention (Capital and Coast DHB 2005), particularly due to the introduction of a guaranteed income.

Preliminary evidence from ASPIRE and other bulk-funding initiatives led providers at the June forum to express a clear desire to change from the fee-for-service to a bulk-funded or package of care model. They believe this kind of purchase framework would not only give them the flexibility to adjust packages of care to the particular needs of a service user, but would also allow them to undertake more substantial organisational and workforce development to improve the work environment for support workers. They anticipated having scope to allocate support workers greater time to undertake identified tasks, and the potential to develop employment practices that guarantee a proportion of hours of work and incorporate ongoing training and supervision. However, providers also agreed that whatever form the purchase model takes, more funding is required to make any headway in this sector with training, recruitment and retention.

Part of the ASPIRE trial is an investigation of the effectiveness of restorative home care. If restorative models of care are effective in restoring functional ability in older people, increasing longevity, reducing hospital admissions and delaying entry into permanent aged residential care, there will be implications for funding and purchasing models. Current purchasing frameworks (hourly basis / fee for service) do not provide the right incentives for improvements in people's functioning, and in fact boost the incentive to increase the number of hours of support provided. An alternative purchase model (bulk-funded / packages of care) with a gain share clause (whereby improvements in function lead to a decrease in service usage) would mean the gains will be shared by the funder and provider. This may provide better incentives for achieving the Government's aims of restoring functioning.

Bulk-purchasing arrangements allow service providers to determine the right input mix to clients, which will include not just hours of care but optimal levels of supervision and training of staff and guaranteed hours for staff, ensuring the right service is provided to clients. The principle behind this is that the service provider is best placed to determine the most efficient use of funding to achieve the desired outcomes, not the Government.

Providers accept that wider implementation of this purchase model would need to be underpinned by changes in home-based service specifications and the development of monitoring and reporting mechanisms to match devolved provider responsibility.

Key issues

- A number of providers are seeking a change in the purchasing model, together with an increase in funding to enhance their capacity to train workers.
- Providers want national reform of the current purchasing approach for home-based services, towards a model that allows a 'package of care' funding approach.
- Providers believe that this new purchasing approach would enable them to develop the organisational capacity required to improve workforce development systems, and work towards compliance with the HCSS Standard.

3.6 Improving information collection and analysis, and communication within the sector

Significant gaps in the collection and analysis of workforce data, a problem identified by HWAC in the New Zealand Health Workforce Stocktake Report (HWAC 2002), continue to be an issue across the health and disability sector. Despite the fact that the non-regulated workforce (including support workers) comprises a significant proportion of the health workforce, due to lack of co-ordination of planning, development, research or review it is difficult to give an accurate indication of its size (Acqumen 2006).

Ongoing data collection on the support workforce, provider development and service coverage is essential for informing decision-making on investment in care services in the community. The lack of uniform, national, comprehensive and up-to-date information on this workforce continues to hinder the ability to analyse and plan for the support workforce to meet future service needs.

There is currently work under way, as part of DHBNZ's Health Workforce Information Programme, to collect data on the support workforce as part of the wider spectrum of non-regulated workers. Outputs from the programme are intended to provide:

- base data describing the demographic and skill composition of the workforce, including flows into and out of the community care sector and inter-district flows
- specific information requests to support policy development
- modelling and forecasting based on the collection of base data.

Exploratory work will be undertaken to examine the systems and data collection possibilities for a non-government organisation workforce base data. Without an estimate of the size and breakdown of the labour force employed in the delivery of non-DHB-provided support services, trends in the employment and training levels of support workers cannot be accurately determined.

Improving health workforce information systems requires that providers have adequate infrastructure to collect and report workforce information, and that there is uniformity between providers in the methods used. This represents a significant cost, particularly to small providers, and it should not be assumed that all providers currently have well-developed information systems in place, or the analytical capacity to support their development.

Providers at the June forum expressed a desire for stronger networking and co-ordination of communication within the support sector to facilitate a national approach to consistency in planning workforce development.

4. CONCLUSIONS

Progress on the priorities identified in the Quality and Safety Project represent steps towards stabilising care and support services in the community, and developing this sector to attract a committed and skilled workforce. The main progress has been in training, but there is still much work to do in this area and more specifically on the HCSS Standard and purchasing models.

CSSITO and the Disability Services Directorate are piloting new training for lifelong disability support workers with the Home Based Support Services Training Initiative. CSSITO is also looking at training needs for all support workers in the ongoing development of a career pathway for support workers. However, before the support sector can really move forward, a co-ordinated approach needs to be taken by the health sector to design scopes of practice for support workers to ensure that what CSSITO and others are doing will meet the needs of the health sector.

Evidence suggests that to ensure quality of care, standards should be mandatory. This could take time to implement because of a lack of resources in smaller providers, and possibly requires an increase in funding and phasing in over time through contractual changes.

There appears to be a consensus that for home-based support services, a bulk funded / packages of care purchasing model would provide better incentives for providers to train and develop a well-qualified and competent workforce, ultimately leading to better care for people with lifelong disabilities and older people.

While this important activity is under way, providers continue to voice strong concern that without further significant investment, aged care and disability support services in the community will continue to be plagued by poor retention of staff and associated quality and safety issues for service users. Substantial further investment is required to ensure that this sector is stabilised, and keeps growing to meet the needs of our ageing population.

HWAC acknowledges the committed efforts of many organisations to improve service delivery and employment practices, but also recognises that progress towards what are now well-accepted directions for the development of sustainable support services continue to be hampered by a purchase model that does not give providers adequate scope to advance organisational and workforce development.

It is HWAC's view, based on the Care and Support in the Community Setting forum in June 2006, that there is a high level of consensus among both support services providers, CSSITO, DHBs and other funders on the way forward. The vision of safe and high-quality care and support in the community setting has not changed. The goals of the Quality and Safety Project for a mandatory home-based sector standard, compulsory training for support workers providing personal care services and a shift towards a 'package of care'-oriented purchase model are still relevant.

The sector has a strong commitment to these goals, and a desire for increased collaborative activity to get there. However, two years after the Quality and Safety Project it is clear that only further investment in the sector to bridge the gap between current practice and these desired outcomes will result in the level of workforce development required for stable and sustainable service delivery.

5. RECOMMENDATIONS

To this end HWAC recommends that:

1. purchasing of home-based support service moves from the predominant 'per hour, per client' funding model to a 'packages of care' model, to enable providers to guarantee support workers set hours of work and to have greater flexibility in facilitating training and supervision

2. findings from the Assessment of Services Promoting Independence and Recovery in Elders (ASPIRE) trial inform the development of service specifications for home-based support services for older people

3. Home and Community Support Sector Standard NZS8158:2003 be made mandatory by 2008, with extra funding provided for implementation, compliance and audit

4. increased funding should be phased in, contingent on providers having an ongoing orientation, training and development package for all staff – this could be achieved through contractual changes over time

5. the emerging career framework for the support workforce be formalised to include competencies linked with the New Zealand Qualifications Framework

6. the Ministry of Health be invited to provide leadership and oversight for the continuing development of the support workforce.

APPENDIX 1: Participants at the *Care and Support in the Community Setting* June Forum (9 June 2006, Wellington)

Jane Cumming	New Zealand Home Health Association
Pat Curry	Nelson Marlborough District Health Board
Sue Seymour	Nelson Marlborough District Health Board
Eileen Brown	Council of Trade Unions
Gill Genet	CSSITO (Community Support Services Industry Training Organisation)
Nicky Murray	CSSITO
Ruth Kibble	Presbyterian Support Otago
Julie Martin	Presbyterian Support Northern
Marese McGee	Chair, NRID (National Residential Intellectual Disability Providers)
Jayne McKendry	Age Concern
Shereen Moloney	Capital and Coast District Health Board
Max Reid	Capital and Coast District Health Board
Glenda Rich	Access Home Health
Angela Wilson	District Health Boards New Zealand
Marilyn Rimmer	District Health Boards New Zealand
Melanie Ryan	Health Care Providers NZ
David Timms	IHC New Zealand
Lisa Williams	Mosgiel Abilities
Sue Hope	Healthcare of New Zealand
Brett Marsh	Spectrum Care
Robyn Shearer	Mental Health Workforce Development, Ministry of Health
Frances Hughes	HWAC (Health Workforce Advisory Committee) member
Suzanne Win	HWAC member
Marilyn Goddard	Workforce Team, Ministry of Health
Jenny Prentice	Workforce Team, Ministry of Health
Judy Glackin	Workforce Team, Ministry of Health
Deb Kerry	Health of Older People Team, Ministry of Health
Amanda Burgess	Health Workforce Advisory Committee Secretariat
Fi Coster	Health Workforce Advisory Committee Secretariat
Mel Downer	Health Workforce Advisory Committee Secretariat

Other organisations invited to the June forum and consulted via electronic means included: the Participate Network; Disability Services Directorate, Ministry of Health; Family Planning Association; various DHBs; Platform; CCS; Workbridge; ElderCare New Zealand; and Nurse Maude Association.

APPENDIX 2: List of submitters to Care and Support in the Community discussion paper

No.	Name	Position	Organisation
1	Mark Nalder	Service Manager	Nelson Marlborough DHB
2	Andrea Corbett	Senior academic staff member	Dept of Nursing, Western Institute of Technology at Taranaki, New Plymouth
3	Anonymous	Nil	Nil
4	Gary Watts	Project Manager	Sigjaws
5	Joanne Edwards	Portfolio Manager	Wairarapa DHB
6	Gabrielle Scott	Co-ordinator Child Development Services	Palmerston North Hospital
7	Robyn Shearer	Project Manager – Workforce	Mental Health Directorate, Ministry of Health
8	Allan Bruce	Senior Analyst	Health of Older People Sector Policy Directorate, Ministry of Health
9	Carole Kell	Service Development Manager	DEALS Inc
10	Carole Maraku		Pou Arahi Te Upoko o Nga Oranga o Te Rae
11	Paul Martin	CCS Southern Regional Manager	Waitaki/Otago Southland
12	Stella Thorp	Nil	Nil
13	Dixie Signal	President	Kimberley Residents Support Group (Hawke's Bay)
14	Malcolm Scott	Relationship Co-ordinator	Health & Social Services Sector, Faculty of Health & Sciences
15	Numbering Error	Numbering Error	Numbering Error
16	David Sloane	Manager	Hamilton Residential Trust
17	Juli Stickler	Service Manager	Healthcare NZ
18	Jacki Richardson		Spectrum Care Trust
19	Richard Belton		
20	Dianne Roy	Lecturer	School of Health Science, Unitec
21	Jayne McKendry	Support & Development	Age Concern NZ
22	Christine Low		National Council of Women of New Zealand (NCWNZ)
23	Nicky Murray		CSSITO
24	Paul Barber	Policy Advisor	NZ Council of Christian Social

			Services
25	Tangi Suzuki	HR Secretary	Healthcare of NZ
26	Lauren Prosser	Senior Policy Analyst	ACC
27	Jane Cumming	Executive Officer	NZ Home Health Association
28	Adrienne Henderson	Divisional Manager Quality Assurance	Royal NZ Foundation of the Blind
29	Philippa Cole	Administrator	College of Nurses Aotearoa
30	Julian Jensen (Mrs)	NZ Registered Dietitian	NZ Nutrition Foundation, Older Person's Working Group
31	Wendi Wicks	National Policy Researcher	Disabled Person's Association (NZ) Inc
32	Barney Cooper	General Manager	Dunedin Community Care Trust
33	Sheree East	Director of Nursing	Nurse Maude Association
34	Eileen Brown	Policy Analyst	NZ Council of Trade Unions
35	Angela Wilson	Project Manager – Workforce Development	District Health Boards NZ
36	Verna Schofield	National President	NZ Association of Gerontology
37	Melanie Ryan	Policy Advisor	Healthcare Providers NZ
38	Sheree East	Director of Nursing	Nurse Maude Association
39	Christane		insightcr@xtra.co.nz
40	Shona Mabon	Manager	Timeout Carers Bureau
41	Mark Garisch		Bay of Plenty District Health Board
42	Robyn Klos	Chief Executive	Gracelands Group Of Services

APPENDIX 3: Quality and Safety Report: inclusions and exclusions

The *Quality and Safety Report* defined a disability support worker as 'an individual who, under full or part time (or other) employment agreement with a provider, delivers the disability support services defined in the project scope':

Included:

A. Vote Health–funded services

- home-based disability support services
- physical disability community support
- intellectual disability community support

Long-term residential support:

- rest-home care
- continuing care hospitals
- dementia units
- continuing care specialised/psychogeriatric
- physical disability
- intellectual disability

Respite support:

- rest-home respite
- dementia unit respite
- continuing care hospital respite
- hospital specialised – psychogeriatric
- community-based respite
- intellectual disability / physical disability community & residential respite
- Regional Intellectual Disability Support Accommodation Services (RIDSAS)
- Ageing in Place pilots
- supported independent living
- rehabilitation and habilitation services
- day vocational programmes and day-care services

B. ACC-funded services (contracted support agencies only)

- residential support services
- home-based support services

Excluded

Vote Health funded services not included

- hospital support workers within forensic services who work in RIDSAS
- unregistered diversional therapists / recreation officers
- personal health funded support services in community settings
- palliative care
- mental health support settings
- unregistered workers in the hospital setting

Other services provided in the sector that are linked but not included

- services privately supplied by retirement villages
- volunteers and client-funded carers
- children receiving services in an educational setting
- privately contracted support workers

Relevant services not included in this scope (eg, personal health services provided by DHBs) were considered when formulating the policy recommendations to achieve quality and safe services for the future.

APPENDIX 4: DHB aged care and disability support workforce development

Following is a brief summary of DHBNZ's Future Workforce Programme discussion paper: *The Non Regulated Workforce in the Health and Disability Sector*, May 2006.

In 2005 District Health Boards (DHBs) developed a collaborative strategic plan, Future Workforce, which identifies the sector's priority actions over the next five years to advance development of the health and disability workforce.

To action this plan, DHBs established six workforce strategy groups to provide a focus for workforce development related to key workforces. DHBs identified the non-regulated workforce as a key workforce for the future of New Zealand's health and disability services. As a result, the Non-Regulated Workforce Strategy Group commissioned a paper in late 2005 to define and undertake a scan of the work that has been completed and is currently under way on the non-regulated workforce.

It was anticipated that the themes emerging from the scan would help to identify priorities for the development of the non-regulated workforce in the health and disability sector. A draft report has been prepared, and the sector is currently being consulted on the Strategy Group's recommendations for future DHB priorities to develop the non-regulated workforce.

The work of this current paper, HWAC's Care and Support in the Community project, focuses specifically on the disability and aged care support workforce and falls within the ambit of draft Recommendation 4, and particularly draft Recommendation 5, to build on existing DHB and Ministry of Health work undertaken as a result of the Quality and Safety project:

> ***Recommendation 4:*** *Work with other stakeholders to develop a strategic industry-based training framework that develops the non-regulated workforce as a single workforce with the potential for staircasing into the regulated workforce.*
>
> ***Recommendation 5:*** *As a priority build on existing DHB and Ministry of Health work that has been undertaken as a result of the Quality and Safety project, and focuses on the traditional home support workforce.*

It is intended that this project develop concrete recommendations to contribute to and support the work of DHBs in developing the non-regulated workforce – in particular that participants consider how recommendations would fit with the DHB proposal to establish a strategic industry-based training framework that develops the non-regulated workforce as a single workforce with the potential for staircasing into the regulated workforce.

APPENDIX 5: Groups consulted by the Quality and Safety Project team

Sector Reference Group

Philip Patston	Ripple Trust
Dick Stark	Grey Power
Ingrid Thomas	Nurse Maude Association
John Baird	Presbyterian Support Services
Paul Gibson	CCS
Tracey Ramsey	IHC
Shane Te Pou	Te Roopu Taurima o Mana kau Trust
Wendi Wicks	Disabled Persons Association
Deo Prasad	Pacific Island Health Care Trust
Eileen Brown	New Zealand Nurses Association
John Ryall/Jack Byrne	Service and Food Workers Union / Council of Trade Unions
Rosemary Burns	ACC
Mike Gourley	under-65 consumer rep
Jill Williams	over-65 consumer rep

Key Government Stakeholders Group

Ministry of Health Expert Advisory Group

APPENDIX 6: Health Workforce Advisory Committee: National Guidelines for the Promotion of Healthy Working Environments

In this report the Committee highlighted that ensuring work places are 'healthy' will be critical to retention of the health and disability workforce. The six principles for a healthy working environment represent a vision for an ideal working environment for support workers in this sector.

Principle One: Organisational Culture (norms, values, beliefs and behaviours)

A healthy work environment:

- will have the health and wellbeing of the person as its primary objective
- reflects a culture that values employees and promotes trust between staff
- demonstrates people working collaboratively as teams and forming constructive relationships to achieve shared objectives
- enables effective and open multi-level communication channels
- encourages and supports change and innovation
- fosters creativity
- promotes continuous learning
- has a risk management approach that supports staff and is not simply risk aversion
- recognises and adapts to changing work–life balance
- reflects a culturally aware environment that is supportive of, and responsive to, the increasing diversity of the workforce.

Principle 2: Leadership and Decision-Making

- Governance structures and systems support staff involvement in decision-making, implementation and the review of initiative success in their area of expertise.
- Participatory management is commonplace, with staff involved in decision-making in their area of expertise and influence.
- Partnerships are established between the management and clinical cultures.
- Clinical leadership and shared clinical governance are promoted.
- Professional autonomy and accountability are promoted and valued.
- Leadership is continually developed and supported at all levels of the organisation.
- Leadership focuses on people, their potential, their impact, and what makes them function optimally.
- Effective feedback systems are developed.

Principle 3: Change Management

- Change is managed as a normal and ongoing characteristic of the workplace, and good processes and principles are evident.
- Organisations engage in change management processes that help build and maintain organisational trust.
- Change has a rationale, is managed through action plans, and is monitored to enable future learning.
- Frontline staff are involved in the definition of problems and the design of solutions.
- Change is preceded by robust consultation processes with those who will be affected.
- Opinion is sought and considered throughout the process from all who are involved in, or will be affected by, the change.
- Effective evaluation mechanisms are put in place and used.

Principle 4: Information and Knowledge-Sharing • Excellent information is collected to assist organisations to understand their workplace and staffing needs. • Demographic information is collected about staff and used to customise organisational design. • Evidence about working environment success is collected and shared with the staff and, where appropriate, the sector as a whole. • Comprehensive information is regularly collected about staff satisfaction with aspects of their environment, and is used to inform future decisions and actions to promote a healthier working environment. • Organisations cooperate and share information with each other to help gain a national picture of future trends. • Knowledge and solutions are shared.
Principle 5: Career Development • Staff are developed throughout their employment by high-quality systems. • Individuals are oriented to the work environment by their team. • Career development opportunities are readily available. • Research is recognised as a legitimate work activity where appropriate. • Staff receive feedback on performance and are actively involved in their performance development plan. • Training and continuing education/learning is conducted on-the-job and through professional agencies.
Principle 6: Employee Recognition • Staff are expected to perform well and are recognised appropriately. • Remuneration is fair. • Workloads and skill-mixes are optimally designed. • Casual labour usage is minimal. • There is flexibility in job design and work arrangements. • Clinicians take responsibility for making timely decisions based on expert judgement. • Excessive levels of stress are recognised as an occupational hazard and actively managed and monitored, and effective processes are provided to support affected staff. • Employee assistance is provided where appropriate.

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