Regularising the Home and Community Support Workforce

Advice to the Director-General’s Reference Group for In-Between Travel

July 2015

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**Case studies: current state**

**Support Worker story**

Penny is a middle aged woman who has limited employment history because she has focused on being a stay at home mum while her children were at school. To help supplement the family income she has taken on many part-time jobs across a range of industries. This means that her employment history can look a bit unsettled to prospective employers.

Penny has always avoided educational settings because she finds bookwork challenging and doesn’t like to sit in a classroom. She would much rather get on with things practically. This means that she has no formal qualifications.

Now that her children have left home, she has joined the home and community health sector because she wants to use her life experience and caring nature within her own community.

Penny loves her job and the people she supports; she knows she makes a real difference. Her employer tries to give her the same clients each week but sometimes she is asked to support people she hasn’t met and this can be really challenging as she doesn’t always know what the client likes.

Penny understands why her hours move up and down every week but really wishes they didn’t. She finds it really hard when her hours reduce because she gets less money that week. It makes a real difference when petrol prices rise quickly or something unexpected happens like when her car broke down last week. She has also noticed that it’s a lot harder to get things on hire purchase when you can’t say for sure what your income is.

This story helps illustrate that the majority of Support Workers:

* are women, over the age of 45 with no qualifications.
* find the prospect of gaining a qualification challenging
* have the right values and attitude to support and provide services within the community.

**Case studies: future state**

**Support Worker story**

Penny loves her job. She still thinks of herself as a practical person but is proud of her level 3 certificate and knows she is just as qualified as the young ones coming into the business. The extra money that comes with being qualified helps as well.

She really appreciates the support her employer gave her when she finally decided she would give studying a go. She got paid for her time, had a colleague who had done the course available to help with anything she was unsure of and, best of all, most of the course involved on-the-job assessments and not classroom learning. She can’t wait for there to be enough clients to justify doing the Level 4 certificate – her employer has already said that she’s the next one they’ll put through the course.

Penny is a valued team member and enjoys the weekly team meetings and exchanging knowledge and experiences with the other team members. She knows so many clients who benefit from what she and others learn from these weekly discussions. She also knows clients gain a lot more from the support they get now to help them achieve their goals than they ever did from having their oven cleaned every second week. She still has to clean an oven every now and then, but is glad that much more of her time is focused on delivering what her clients need to be active in their home and wider community.

Penny is still sometimes asked to support people she hasn’t met and knows this will happen from time to time because her employer makes sure there is work for her to do in her guaranteed hours. It’s still a bit challenging but it is much easier with the handover notes and discussion on care plans with her supervisor.

Penny has encouraged her son and a couple of friends to become Support Workers. She knows it’s a good career and getting qualified will help her brother’s boy get into nursing.

This story illustrates that regularising the Support workforce will mean:

* a different demographic of worker will be attracted into the sector
* increased benefits to the client, Support Worker and community
* new ways of working across the sector.

# About this document

| **Area** | **Key observations** |
| --- | --- |
| In-between Travel Settlement Agreement | In 2014 the providers, employees and funders of home and community support services (HCSS) agreed that from I July 2015 Support Workers would be paid for the time they spend travelling between clients at a rate based on the Minimum Wage. The In-between Travel Settlement Agreement (the Settlement Agreement)[[1]](#footnote-1) between the parties also provided for a minimum travel allowance.  Settlement Agreement negotiations led to discussions about the sustainability of the HCSS model of service delivery under the current employment model. As a result, the parties agreed to investigate the impact and affordability of a sustainable, regularised workforce. A Director-General’s Reference Group was established to conduct a review of Vote: Health-funded HCSS (the first work stream), and to report on the impact and affordability of transitioning to a regularised workforce within two years of ratification of the Settlement Agreement (the second work stream).  A ‘regularised’ workforce was described by the Settlement Agreement parties as one that provides:   * guaranteed hours for the majority of the workforce * paid training to enable Support Workers to gain Level 3 New Zealand Certificate qualifications * wages based on the required levels of training for Support Workers * a case-load and case-mix workload mechanism to ensure a fair and safe allocation of clients to Support Workers.[[2]](#footnote-2) |
| Working group membership | Members of the second work stream (Working Group Two) were:   |  |  | | --- | --- | | Ruth Anderson, Health Workforce New Zealand | Mark Hodge, ACC | | Laurie Biesiek, District Health Board (DHB) Shared Services | Sam Jones, Service and Food Workers Union | | Virginia Brind, Tairawhiti DHB | Tony O’Rourke, Ministry of Health | | Kereana Buchanan Accident Compensation Corporation (ACC) | Graeme Titcombe, Access Health | | Anita Guthrie, Healthcare of New Zealand Holdings Limited (HHL Group) | Melissa Woolley, Public Service Association. | |
| Scope of the report | This report relates to Vote: Health-funded Support Workers who deliver home-based care to disabled clients and those aged 65 and over. The same workforce supports and provides care for ACC clients recovering from a short-term injury or requiring ongoing home-based care. ACC was not a party to the Settlement Agreement because it relates to Vote: Health funding only. However, ACC has agreed to negotiate arrangements, subject to the satisfaction of all relevant parties, which will have the effect of ACC paying for in-between travel at similar rates to those agreed in the Settlement Agreement.  The report does not cover the workforce that works in:  1. services or activities provided in Vote: Health-funded residential facilities (including residential facilities for people with disabilities)  2. mental health services  3. services funded through an individualised funding package. |
| Caveats | The following caveats apply to this report.  1. All three funders (Ministry of Health, ACC and the DHBs) apply a national pricing model that is sufficient to support a regularised workforce.  2. The DHBs take a consistent price/cost approach to the funding of HCSS under a national contract.  3. All recommendations in this report are fully funded (to avoid future risks to the safety of clients, or to the workforce, or to the sustainability of the service providers).  *Implementation of regularisation will not be possible without national pricing and national contracting.*  In addition, it should be noted that, in principle, ACC supports the recommendations for moving towards a regularised HCSS workforce as it relates to Vote: Health funding. ACC has provided advice on and support for the development of these recommendations and is committed to supporting the regularisation of the HCSS workforce, but notes that because ACC is not a party to the Settlement Agreement, ACC is not covered by these recommendations.  Once the recommendations have been finalised by the Director-General’s Reference Group and the Minister of Health, ACC will consider what operational, contractual and pricing changes will be needed to support their providers to move towards a regularised HCSS workforce. This process will be subject to approval from ACC’s executive and board, as well as the Minister for ACC. |
| Potential risks to be mitigated to support the transition to regularisation | Before implementation of regularisation, there are a number of potential risks that must be considered and mitigated:  1. the impact of client choice on a regularised workforce (ie, the more client choice, the greater the impact on service delivery and provider costs)  2. workers’ preference for guaranteed hours, as not all will wish all or part of their hours to be guaranteed  3. ACC has not yet undertaken work relating to non-utilisation rates  4. should ACC not offer guaranteed hours, this will have a significant impact on providers’ ability to deliver guaranteed hours in accordance with the recommendations set out in the report. |

# Executive summary

| **Area** | **Summary statement** |
| --- | --- |
| Executive summary | 1. Regularisation of the home and community support service (HCSS) workforce is both feasible and desirable for all parties and will support all service delivery models.  2. The benefits of regularisation include:  a. increased quality and consistency of services delivered to clients  b. increased worker capability to be responsive to client needs, greater certainty of employment and income for workers, support for worker training, recognition of training for workers, and a better articulated career pathway for Support Workers  c. enhanced provider capacity to be able to recruit and retain their workforce, to be responsive to fluctuations in client needs, and to respond to changing models of care  d. increased consistency and transparency in the basis for determining service delivery funding, increased accountability of providers for the use of allocated funding, and access to improved workforce and service delivery.  3. There are risks for all parties in regularising the HCSS workforce.  a. *For clients:* clients may have less choice about who delivers services to them and, potentially, when those services are delivered, although these disadvantages are expected to be offset by enhanced quality and consistency of services.  b. *For Support Workers*: Support Workers may lose the flexibility of being able to agree a variation to rostered service delivery times at short notice in order to accommodate unplanned events (depending on rostering and organisational practices).  c. *For providers:* providers may not have sufficient ongoing client volumes or funding to support a regularised workforce, although this can be managed through change management processes to review the number of guaranteed hours individuals have across the workforce.  d. *For funders:* funding to support a regularised workforce will be increased in the short term (and on an ongoing basis). However, the expected benefits in service consistency and quality and the positive impact on supporting people to remain in the home longer may only become evident in the long term.  4. A staged whole-of-sector approach to the transition to a regularised workforce is recommended. This includes setting up a transition group to have oversight of, and manage, the transition process. The Transition Group must include the participation, as equal partners, of: the Ministry of Health (in its role as manager of Crown funding), the Ministry of Health (as funder of Disability Support Services), ACC, DHBs (in their capacity as funders and providers), and provider, union and client representatives.  5. This report recommends a suite of interventions that must be implemented in their entirety if regularisation (as described in the Settlement Agreement) is to be achieved. The interventions set out here must not be implemented separately over a period of time, irrespective of the proposed length of time. To do so would jeopardise the potential success of the initiative and, importantly, prompt the loss of good will on the part of the DHBs, providers and unions as parties to the Settlement Agreement. |
| Executive summary (continued) | 6. A separate initial Crown Budget bid is necessary to ensure the sustainability of the sector in advance of regularisation and retention of the current workforce. This budget bid should be sufficient to ensure that all providers are able to allocate $27.76 per hour per Support Worker (exclusive of in‑between travel payments) as a baseline. With payment of the baseline, providers should be expected to pay a minimum of $15 per hour per Support Worker prior to regularisation and prior to the application of wage rates linked to qualifications. Further work is required to determine the level of funding recommended. |
| 7. To support regularisation, sufficient additional Crown funding must be allocated to enable funders and providers to implement each stage of transition to a regularised workforce. An expectation of funding for regularisation is that funding allocation should be linked to contractual performance.   |  |  | | --- | --- | | The cost implications of: | have been estimated at an increase to current baseline funding of: | | i) Support Worker wages being paid on the basis of the required levels of training | between 5.87% and 14.6 % (with the higher rate aligned to a remuneration framework comparable to that applicable to DHB-employed Health Care Assistants) | | ii) providing paid training time to enable obtaining the Level 3 New Zealand Certificate qualification | 1.17% | | iii) the majority of support workers being employed on guaranteed hours | 2.49%, which includes:  a. a time allowance of 0.5 hours per week per Support Worker of non-revenue-generating time (meetings, supervision, quality control, mentoring)  b. a 3% addition to price, in recognition of the risk of being required to pay workers for non-revenue-generating time (where 51% of Support Workers are employed on guaranteed hours)(may increase up to an estimated 20% when 80% are employed on guaranteed hours). |   The cumulative cost implications are an increase to baseline of between 11.54% ($60.23 million) and 20.74% ($108.26 million), with the higher rate aligned to a remuneration framework comparable to that applicable to DHB-employed Health Care Assistants.  The 2013/14 DHB and Ministry of Health Disability Support Services (DSS) actual spend, plus budgeted In-Between Travel funding, has been used to determine baseline costs of $522 per annum ($295 million DHB costs, $189 million DSS costs and $38 million In-Between Travel funding).  8. Should regularisation not be implemented, many commentators (including Deloitte Touche Tohmatsu Limited in their 2015 *Financial Review & Risk Analysis of the Home and Community Support Sector*) have argued that the HCSS sector will be unsustainable. This will have a serious ongoing negative impact on service delivery and maintenance of service quality. |

# Recommendations for regularisation

| **Area** | **Recommendations** |
| --- | --- |
| Establishment of the Transition Group | 1. A cross-sector transition group should be established to implement, assess, monitor and review progress towards the achievement of regularisation, ensuring employees have adequate independent representation, and employers are supported to comply with the settlement and legal requirements. The transition group should include representatives of the Settlement Agreement parties, including the Ministry of Health, ACC, DHBs, providers, unions, and clients. Consideration should be given to ensuring the interests of Māori, Pacific people and rural and small providers are taken into full account. |
| Wage rates consistent with those in the established remuneration scale for workers performing similar tasks and requiring similar qualificationsMajority of workers employed on guaranteed hours | 2. It is recommended that:  a. wage rates be consistent with those contained in an established remuneration scale, whereby workers are expected to have comparable skills, responsibilities and knowledge to meet the needs of similar clients and undertake similar tasks (eg, Health Care Assistants working for DHBs)  b. funding be included in a consistent price/cost model to enable paid training to Level 3 for all Support Workers.  3. It is recommended that:  a. provisions covering employment status, guaranteed hours and changes to employee hours of work be included in employment agreements  b. the initial level of guaranteed hours be set at the 51% model, taking into consideration the associated caveat regarding funding availability  [Under the 51% model, providers are expected to achieve the following *minimum* targets for guaranteed hours by the end of the first year:   * a minimum of 51% of each provider’s total workforce has guaranteed hours * a minimum of 51% of each provider’s contracted hours will be guaranteed * each Support Worker with guaranteed hours will have their last three months of hours reviewed, and the hours deemed to be permanent will make up the number of hours guaranteed, to a maximum of 40 hours per week.]   c. the percentage of workers on guaranteed hours increase over time to meet staged implementation milestones  [Over a three-year period from the date of the signing of the Settlement Agreement, all providers will be required to work towards the aspirational goal of 80% of their workforce being on guaranteed hours (taking into account the requirements of the Employment Relations Act 2000).]  d. the price/cost model include a percentage to recognise provider risk (nominally set at 3%).  [Australian reports indicate the level of risk increases up to 20% depending on the percentage of a worker’s hours that are guaranteed and the degree of client choice taken into consideration.]  e. more work be undertaken to ascertain the level of risk that needs to be included in the price/cost model for providers before implementation, because the current figure of 3% is an estimate developed to illustrate the price/cost model and needs to be subject to further consideration  f. further investigation be undertaken into the impact of guaranteed hours on client choice and what can be done to address this  g. change management processes be agreed in advance of the introduction of guaranteed hours. |
| Enable training to Level 3 within two years | 4. It is recommended that the following arrangements for training be implemented:  a. all Support Workers are enabled to undertake training for a Level 3 qualification within two years of commencing work  b. Support Workers are paid for training at their usual hourly rate  c. training (normally) takes place at work using an embedded (in-house) training model. |
| Implementation of a national service-level contractDetermining the funding envelope for service delivery | 5. A national service-level contract that includes service delivery specifications similar to the Aged Related Residential Care Agreement (ARCC) model be implemented. |
| 6. It is recommended that:  a. progress towards implementation of the Health of Older Persons’ client assessment model (InterRAI) assessment be accelerated, with full implementation expected by the end of 2016  b. funders determine their funding envelope for HCSS based on identified packages of care and service volumes  c. funders determine packages of care for recipients of HCSS, based on assessment outcomes  d. funding is based on agreed national average inputs per case-mix category.  [Each client is allocated a ‘package of care’ based on their InterRAI-assessed case-mix category. Each case-mix category funding would be based on agreed national average inputs (with nationally agreed maximum inputs per case-mix category), calculated at the agreed national pricing level. Those clients requiring services above the nationally agreed maximum inputs per case mix are agreed between the parties and funded on a ‘fee-for-service’ basis.] |
| Application of a price/cost model to identify service delivery costsPrice/cost to be reviewed annuallyReporting, monitoring and compliance | 7. It is recommended that:  a. the HCSS Costing Template (the ‘price/cost model’), jointly developed by the DHBs through the Health of Older People Steering Group and the New Zealand Home Health Association[[3]](#footnote-3) in 2014, be used to determine the price of service delivery for aged care HCSS services, and that this form the basis of negotiation for the annual review of the national HCSS contract (noting that this would be under a sector representative framework and would use a process similar to the annual aged residential care contractual review).  b. the price set in funder/provider negotiations be reviewed annually  c. providers and funders meet contractual expectations relating to the implementation of regularisation and provide regular data in accordance with compliance requirements. |

# Transitional arrangements to achieve regularisation

| **Area** | **Key observations** |
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| Objective | The viability of HCSS depends on the transition, at one time, of all the measures that make up a regularised workforce (ie, paid training; wages linked to the required levels of training; guaranteed hours; and safe and fair workloads, in accordance with the timetable set out here). Implementation of a complete package will enable recruitment and retention problems to be addressed and will create a more experienced and stable workforce, well placed to meet increasing demand in the future. |
| Timeframe for implementation | Transitioning to a fully regularised workforce, as defined by the Settlement Agreement, is only achievable within 36 months of the signing of the Settlement Agreement and will require a careful and consistent approach, provider by provider, to ensure no disadvantage to the workforce, and buy-in by employers, workers and providers through education and robust consultation. |
| Essential prerequisite: sufficient funding and accountability mechanisms | The following paragraphs set out the transitional arrangements required to enable regularisation within a 36-month period from the date of the Settlement Agreement having been signed.  A separate initial Budget bid for new Crown funding must be made to ensure:  a. providers’ ability to support the allocation of baseline funding equivalent to $27.76 per worker (excluding in-between travel payments) and $32.50 per worker (including in-between travel payments) and payment of an initial minimum entry wage rate of $15 per hour  b. support for transition to a regularised workforce. |
| Staged approach to transition | Funders and providers will need to be assured that sufficient funding is available to support regularisation of the home and community support workforce.  Providers will need to demonstrate accountability through meeting staged contractual obligations before full funding is allocated.  The total quantum required for implementation of regularisation has been estimated at between $60.23 million and $108.26 million, with the higher rate aligned to a remuneration framework comparable to that applicable to DHB-employed Health Care Assistants. This funding is *additional* to that appropriated for payment of in-between travel.  It is not anticipated that the total quantum of funding to support regularisation will immediately be available to funders for allocation to providers, but that sufficient funding to support each stage of transition to a regularised workforce be made available to providers to support implementation in accordance with an agreed timeframe for the implementation of each stage. |
| Transition Stage One (anticipated to take at least 12 months) | Transition Stage One requires:  a. any suggested rates or funding estimates included in this report to be peer reviewed and verified by an independent party before this report is published and verified by the parties to the Settlement Agreement  b. consideration of the impact of client choice on a regularised workforce, because this will have an impact on service delivery and provider costs  c. completion of all InterRAI assessments for persons aged over 65  d. the development and agreement of contract service specifications for persons aged over 65, for inclusion in a national contract  e. a review of the experience of other health sectors, such as the Australian introduction of guaranteed hours for the home and community support workforce, and/or New Zealand experiences, to analyse the risk of non-utilised (non-revenue-generating) time |
| Transition Stage One (continued) | f. the Ministry of Health, in conjunction with all stakeholders (including funders, DHBs, providers and unions), to establish a national contract similar to the current Aged Related Residential Care (ARRC) agreement, which will include service specifications that:   * mandate the use of the price/cost model (developed in 2014 by the DHB Health of Older People Steering Group and the (now) Home and Community Health Association) for HCSS as a basis for negotiations between DHBs and providers with respect to aged care services * include annual contracting mechanisms that enable statutory requirements that affect price to be taken into account   g. the establishment of an education and support programme that will inform funders, providers, unions, workers and clients of the purpose of regularisation, the processes of transitioning to a regularised workforce, and their role and obligations in relation to this transition  h. providers to complete a stocktake of current workers’ hours, rostering, existing qualifications and casework allocation  i. reporting on the delivery of associated milestones and outcomes. |
| Transition Stage Two (to be undertaken concurrently with Stage One and completed within six months of Stage One’s completion) | Transition Stage Two requires:  a. changes to individual and collective employment agreements to be negotiated and agreed in accordance with employment law  b. DHBs to transition to the funding allocation being determined on a case-mix volume basis: the formula for determining this will be identified/agreed in Transition Stage One  c. allocation of up-front funding to DHBs to transition to a 51% guaranteed hours model and link wages to qualifications  [Under the 51% model, providers are expected to achieve the following *minimum* targets for guaranteed hours by the end of the first year:   * a minimum of 51% of each provider’s total workforce has guaranteed hours * a minimum of 51% of each provider’s contracted hours will be guaranteed * each Support Worker with guaranteed hours will have their last three months of hours reviewed, and the hours deemed to be permanent will make up the number of hours guaranteed, to a maximum of 40 hours per week (noting the associated caveat that this will depend on appropriate funding which must be based on analysis of non-utilisation rate and other factors, such as turnover (of clients and staff).   d. providers to recognise current qualifications, link wages to qualifications, and demonstrate through completion of regular reporting that this expectation has been met  e. allocating required funding to support training to enable all Support Workers to have access to Level 3 qualifications  f. reporting on the delivery of associated milestones and outcomes. |
| Transition Stage Three (to be undertaken concurrently with the latter six months of Stage Two and completed within a further six months) | Transition Stage Three requires:  a. implementation of increases in each element of the 51% guaranteed hours model  b. reporting on the delivery of associated milestones and outcomes. |

# Background

| **Area** | **Key observations** |
| --- | --- |
| Purpose of the report | This report provides advice to the Director-General’s Reference Group on the impact and affordability of a transition to a regularised home and community support service workforce. A regularised workforce is one that has:   * the majority of workers employed for a guaranteed number of hours * paid training to enable Support Workers to gain Level 3 New Zealand Certificate qualifications * wages paid on the basis of required levels of training * a case-mix / case-load mechanism to ensure a fair and safe allocation of clients to Support Workers.   The benefits of moving to a regularised Support Worker workforce are transferable across all service delivery models. A well-trained workforce, working guaranteed hours (with support from a casual, fixed-term workforce), will be able to deliver high-quality health care and respond to future fluctuations in demand. A regularised workforce will be well placed to accommodate any changes in service delivery models.  The terms of reference for the report are set out in Part B to the Settlement Agreement between the providers of HCSS, the unions representing Support Workers, and the DHBs and the Crown as funders of those services. |
| Costing model | In 2014 the DHB Health of Older People Steering Group in conjunction with the (now) Home and Community Health Association developed a Home Support Services Costing template to articulate the costs and service inputs of a home-based service on a per-hour basis. The costing model template is published on the DHB Shared Services website to inform discussions and decision-making on service investment and pricing decisions to ensure that sustainable, cost-effective home and community services are maintained across the country.  This template is suitable for all funding arrangements, including fee-for-service, restorative care and a case-mix approach to funding. It is intended to make provider and DHB funding decisions transparent, and to itemise the standard costs associated with the delivery of HCSS. The template has been used throughout the report to illustrate the cost implications of regularising the HCSS workforce. A copy of the template and the assumptions underpinning it can be found in Appendix 1.  The Ministry of Health uses a similar costing template to discuss and agree the contract price for providing home-based services to disabled people (currently $26.10 per hour), not taking into account the costs of in-between travel.  Providers operate within a competitive environment and may choose to offer higher wage rates to attract and retain staff and to compete for DHB contracts on the basis of workforce skill mix and quality of service provision. Alternatively, they may wish to compete on the basis of reduced overhead and/or margin costs. DHBs may choose to make strategic decisions to invest more in home and community services in the immediate term in anticipation of longer-term savings generated as a result of people being able to continue to live in their homes. |
| Ministry of Health Home and Community Support Service Workforce Survey 2015 | The principal source of workforce data in this report is the Ministry of Health 2015 Home and Community Support Service Workforce Survey. The 76 providers listed in the In-Between Travel Settlement Agreement were asked to supply workforce demographic data, including Support Worker hours worked, for the four-week period from 9 February to 8 March 2015. The results of the survey are incorporated in the various sections of this report.  The Ministry received 33 responses to a standard questionnaire from a variety of small and large providers, a response rate of 42%. Collectively, the responses provide wage data covering 11,288 community support service workers. Not all providers were able to supply all of the requested information, and the analysis varies for each component. The applicable sample size is noted in each section. The data is considered to be representative of the sector, and therefore conclusions can be drawn on the demographics of the workforce and, in particular, the probable impact of transitioning to a regularised workforce.  Table 1: Number of Home and Community Support Workers, by employer size\*   |  |  |  |  | | --- | --- | --- | --- | | **Provider size (number of Home and Community Support Workers on payroll)** | **Number of providers** | **Average number of Home and Community Support Workers (3-week average)** | | | **Employed by each provider** | **Worked during the survey period** | | 1−50 | 12 | 26 | 24 | | 51−100 | 7 | 62 | 59 | | 101−200 | 5 | 161 | 156 | | 201−300 | 3 | 248 | 180 | | 301−600 | 3 | 415 | 408 | | 1501+\*\* | 12 | 2344 | 2680\*\*\* | | Total | 33 | N/A | N/A |   \* 33 providers, 11,288 Home and Community Support Workers.  \*\* There are no, or very few employers who have between 601 and 1150 employees in 2015.  \*\*\* This rate for this category is derived from the providers that were able to supply this information. |

# Growing demand and more complex care for HCSS

| **Area** | **Key observations** |
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| Growing demand for home and community support services | The demand for HCSS is expected to grow as the proportion of New Zealanders aged 65 and over increases faster than ever before relative to the rest of the population. People in the over-85 years age group are often living with chronic long-term conditions and comorbidities. The Ministry of Health reports that in 2012/13 approximately one in four people aged 85 years and over lived in aged residential care, which means that an estimated 75% of this age group were still living in their own homes. Government policy supports older people staying in their homes for as long as they can safely do so. The opportunity to live at home is the preferred option for many disabled clients as well. |
| The high cost of hospital and residential care | The generally higher cost of health care delivered in hospital and residential settings, together with increasing demand, has highlighted the importance of fit-for-purpose, sustainable HCSS health care services for people with long-term conditions and age-related illnesses. |
| Addressing service delivery risks | Safe and high-quality home and community support services are achievable if the sector is funded at a level that reflects the actual costs of delivering home and community support services, and attention is paid to putting in place efficient infrastructure to support the delivery of high-quality services. This means the introduction of a sustainable funding model, a national contracting arrangement across the DHBs for the funding of services to older people, and a national pricing model (which spans DSS and ACC, though it may result in a different price). Future models of service delivery will need to respond efficiently to meet a range of client outcomes, including the growing demand for complex care. |
| The need for regularisation | To be sustainable the sector needs to develop and retain a workforce that is capable of delivering care to more clients, and to more clients with complex care needs. The Ministry of Health *2014 Briefing to the Incoming Minister* identified the need to build and support this workforce. The Ministry noted that:  “In particular, an ageing population with increasingly complex needs will require more and better-trained home-based and residential carers to support older people with long-term conditions, either living in their own homes or in residential care.  Good home-based care reduces demand for aged residential care and can be lower cost, depending on the level of support required.  Implementing new ways of working requires the ability to influence key decision-making across that whole system and an explicit ability to incentivise the shift. It requires an integrated approach to align the different moving parts, such as workforce, models of care, information systems, clinical and corporate governance arrangements, regulatory and funding settings” (p.2).  The parties to the In-between Travel Settlement Agreement agreed that (clause 1.4):  A regularised employment model is expected to be beneficial for all parties involved and will ensure continued viability of HCSS as a cost effective alternative to residential care. Regularisation of the HCSS workforce will allow the majority of home care workers to be paid wages based on a regular employment model. This model will help ensure that there are no reductions to client hours as a result of travel time. |
| The need for regularisation (continued) | The 2015 BERL report *Improving the Productivity of Home and Community Support Services*, prepared for the Aged Care Industry Training Organisation (ITO) Careerforce, notes that:  “The workforce is not engaged for regular hours of work, with the burden of training in many instances being placed on the worker. The work lacks status, with many on close to the minimum hourly rate and little exposition of any career path or opportunities to progress in the sector.  Better work conditions, terms and status, including regular hours, will help improve staff retention and therefore reduce recruitment costs. Any long-term improvements in the quality and continuity of care spells wider savings for the health and community care budget by keeping people out of hospital beds or residential care settings for longer. However, these savings will only occur if the home and community support workforce is appropriately trained and qualified to meet the increasingly diverse needs of clients.  Without properly functioning home and community support services, additional costs will fall on other components of the health system (or on other community support agencies). In essence, spending even more money on hospitalisation and residential care instead is the alternative” (p. 2) |
| Implications for clients | Several principles need to underpin service delivery, regardless of the funder. The workforce must be trained to deliver safe and competent care that recognises the cultural needs of the individual and whānau/family, bearing in mind that this is not a ‘one size fits all’ model of care. This also applies to any substitute worker who steps in when a regular worker is away. That person should be briefed on the needs of the client so that the client is not required to update the Support Worker on the content of their care plan at the beginning of a visit.  Support Workers need to be reliable, responsible and respectful. They need to protect a client’s right to privacy and recognise the consequences for the client of any failure to keep an appointment or to arrive late. Providers are encouraged to coordinate the transport arrangements of a disabled client who wants to travel to work; for example, at the appropriate time and not two or three hours later.  This puts pressure on providers to meet the needs of clients at busy times of the day, such as between 7 and 9 a.m. It means that providers must prioritise service delivery when insufficient numbers of staff are available to meet demand. Not all clients will be able to have personal care services delivered at a preferred time at these times of the day (although services critical to a client’s health would be a matter of priority).  Providers are also responsible for providing each client with a seamless ‘invisible’ service even if a regular Support Worker is unavailable. Clients do not want to be involved in rostering or rescheduling rearrangements resulting from Support Worker availability. They want care to be delivered at the agreed time to a high standard by a competent Support Worker. Some degree of flexibility is required on the part of providers delivering a client-centred service that allows clients to have varied routines and take part in community activities. |

# The home and community support workforce

| **Area** | **Key observations** |
| --- | --- |
| Future workforce | Treasury’s *2014 Briefing to the Incoming Minister* pointed out that the success of a shift towards home-based care depends on the workforce that delivers it. In relation to the home and community care workforce, Treasury said that:  We need to look more closely at the role of the care and support workforce in the aged care and disability support sectors. This workforce is important to the health sector’s capability to respond to the ageing population and the increasing prevalence of chronic disease. It is important to the wider workforce because it allows other health workers such as nurses to concentrate on tasks that make better use of their training. A well-functioning, appropriately trained care and support workforce enables people with more complex health needs to be cared for in their home for longer and facilitates earlier discharge from hospital, freeing up hospital beds with a positive impact on patient flows and efficiency*.* |
| Long-term vision for the Support Worker workforce | A long-term vision for the Support Worker workforce is that:  (i) levels of turnover reduce to align with general workforce trends (generally between 8 and 15%)  (ii) Support Workers will be qualified and work as part of a multidisciplinary team  (iii) there is a career path for Support Workers  (iv) a wider demographic, including young people, join and remain in the workforce  (v) the scope of practice of experienced staff is extended to meet the demand for increasing acuity of care  (vi) there are appropriate levels of supervision and client assessment to avoid the risks to clients, Support Workers, providers and funders from inadequate service delivery. |
| Current workforce profile and dynamic | The Ministry of Health 2015 HCSS Workforce Survey confirms that, compared with the total New Zealand labour force, the current Support Worker workforce is female dominated (91% are women) and has an older age profile (54% are aged between 45 and 64). The largest identifiable ethnic group is European (28%), followed by Pacific people (11%). Ethnicity was reported as ‘unknown’ for 42% of respondents to the survey. As this cohort ages it is not being replaced by younger workers, who are more likely to seek employment with a guaranteed income and potential career path.  The home and community service sector operates 24/7, with higher client demand at certain times of the day, particularly in the early morning and late afternoon. This variability of demand has driven an employment model that relies heavily on assignment workers (incorrectly treated as casuals) working split shifts, supported by agency temp staff. The Ministry of Health 2015 Workforce Survey shows that most of the estimated 24,000 Support Workers work part-time, at an average of 21 hours per week (based on an analysis of the hours worked by 7877 workers over a four-week period).  The Deloitte Report found that providers were finding it difficult to recruit and retain staff because of an improving economy and perceived superior opportunities elsewhere.[[4]](#footnote-4) Historically, high turnover leads to a loss of investment in Support Worker training on the part of providers, who find it difficult to recruit trained Support Workers. The work lacks status, and there are few opportunities for career development or progress for Support Workers within the sector. Some clients and the condition of their homes can create a challenging working environment for Support Workers. |
| Current workforce profile and dynamic (continued) | As a consequence, many Support Workers are drawn away by other job opportunities that offer higher wages in less demanding conditions.[[5]](#footnote-5) Some Support Workers move in and out of home and community support services and hold down more than one job to make ends meet. A high degree of knowledge and skill is often acquired by Support Workers who remain in the sector, and this is lost when they leave for better-paid work.[[6]](#footnote-6)  The employment model is based on the assigned client’s needs, which may be ongoing or short term. In the course of a day the same Support Worker might provide services to clients who are funded from one or more of three funding streams (the Ministry of Health for people with disabilities, DHBs for people over 65 years of age, and ACC for people with injuries).  Support Workers work independently in vulnerable people’s homes with very little supervision or oversight. Provider representatives report that the sector is not funded to put in place suitable performance management and supervisory systems to support and check on Support Workers operating in these conditions. They also advise that they are not compensated to meet increasing compliance costs when, for example, new legislation imposes requirements on funders and providers relating to the health and safety of their workforces.  Funding and wages are linked to service provision, and a worker’s income is likely to be lower in any week when a regular client does not require the service (eg, because the client is away or in hospital) and the employer is unable to set up an alternative client visit to make up the shortfall. This also results in the worker using annual leave entitlements to make up their wage, leaving little for adequate rest and recreation. Providers report frustration that current funding arrangements limit their opportunities to provide additional workforce support through regular team meetings, ongoing access to supervision, and mentoring/buddy arrangements for inexperienced staff.  The Ministry of Health 2015 Workforce Survey shows that the HCSS workforce:  (i) is becoming more highly qualified but continues to be paid at or close to the Minimum Wage: 46% have a Level 2 or 3 NZQA qualification, of whom 62% are paid under $15 per hour (41% at the current Minimum Wage of $14.75 per hour), and generally there is no specific recognition of qualifications in wages, although some receive an allowance  (ii) increasingly works consistent hours but has no guaranteed hours of work on a weekly or annual basis: over a four-week period (9 February to 8 March 2015) 41% of those who worked had consistent hours for two of the four weeks; a further 20% had consistent hours for three of the four weeks; and a further 19% had consistent hours for each of the four weeks.  Note: the survey did not report on whether there was any consistency in the time of day or days the hours were worked. |

# Current funding arrangements

| **Area** | **Background information** |
| --- | --- |
| Overview | DHBs and the Ministry of Health pay a range of prices for the delivery of home-and community-based care. The Ministry pays the same rate ($26.14 per hour plus rural travel) for household support and personal care. The price paid for the delivery of household support (assistance with housework) and personal care varies from DHB to DHB, with the price for household management ranging from $21.26 to $25.99, and personal care rates ranging from $24.21 to $34.06.  Many DHBs have shifted their focus from household support to personal care, in line with a restorative and person-centred approach to home-based care. Fifteen DHBs pay providers on the basis of a ‘fee-for-service’ model (where a provider is paid for the number of hours it delivers). Five have moved to a bulk-funding model that applies what is referred to as a case/load case/weighted approach. This approach is explained in subsequent paragraphs.  The variation in pricing and funding models reflects strategic decisions made by DHBs.  A provider of HCSS contracted by the Ministry of Health, DHBs and ACC is paid different rates by each funder, yet may send the same worker to deliver care to a disabled client, an older client or an injured client on the same day. Some providers ‘cross-subsidise’ in order to pay Support Workers the same hourly rate, irrespective of the funder. Others are concerned about the risks attached to this approach and pay different hourly rates depending on the funder.  Historically (and currently) DHB pricing for HCSS has not been based on a fully costed model. DHB funding increases have not kept up with increases in the Minimum Wage and other inflationary pressures. Over the past seven years only three DHBs, ACC and the Ministry of Health have provided increases in the price for HCSS of more than the Minimum Wage.[[7]](#footnote-7) |
| Addressing problems with the current pricing model | To meet Minimum Wage, Kiwisaver contributions and ACC rates obligations, providers have reduced costs by: reducing coordinator to Support Worker ratios; discontinuing pay increases and performance reviews; delaying investment in capital expenditure and maintenance; and not replacing administrative or infrastructure staff. An accumulation of funding shortfalls over time means that some providers are now operating with negative margins. The general picture is of a sector that is not sustainable at the current levels of funding.  The price/cost model provides an opportunity to objectively illustrate the baseline costs of providing HCSS to older people. Applying actual values, where known, industry averages and the median Support Worker wage ($15 per hour) and a 6% return on investment (margin) indicates that the baseline cost is $27.76 per hour (increasing to $32.50 with the addition of costs for in-between travel payments).  This analysis indicates that additional funding is needed to lift the current price paid for HCSS (between $21.26 and $25.99 for household support and between $24.21 and $34.06 for personal care) to a fully costed model in advance of transitioning to regularisation. Provider representatives have indicated that moving to a fully costed funding model in advance of transitioning to a regularised Support Worker employment model will support a minimum pay rate of $15 per hour per Support Worker.  Further work is required to determine the level of funding needed to move to a fully costed model in advance of regularisation and the implications for funders. |
| Problems with fee-for-service and bulk funding arrangements | Provider representatives report that the fee-for-service funding model is not well aligned to a restorative model of care. Clients’ requirements for care are identified in the Needs Assessment and Service Coordination (NASC) assessment and defined as specific support to be provided in specified hours of service delivery. This approach promotes the delivery of services as tasks to be completed within a set number of hours, and there is minimal flexibility to vary either the tasks or the number of hours to reflect a client’s changing needs without a further NASC assessment.  Bulk funding can pose a greater risk to providers because funding is independent of volumes. If contractual agreements (ie, expected volumes and volume conditions and pricing increase adjustments) are not negotiated fairly or monitored correctly, providers can be at greater risk than under the ‘fee‑for-service’ model.[[8]](#footnote-8) |
| Addressing problems with fee-for-service and bulk funding arrangements (case mix) | The funding risks for DHBs and providers are distributed more appropriately under the case-mix model. DHBs become responsible for the impact of their decisions with regard to both service entry and the ‘related services’ that have an impact on home support service levels (volume). DHBs are responsible for:   * the total volume of clients serviced (volume) * variations in the case mix of the client population (change in mix of client population complexity) * service referrals for non-standard clients, outside of normal case-mix variations (volume).   Providers manage the risk for:   * variation of inputs for a known number of appropriately allocated clients within case-mix categories (efficiency) * safe services by utilising appropriately competent and trained personnel (safety).   Nationally agreed minimum safety and service standards and worker competency criteria can be established for each case-mix category. Case mix also encourages Support Workers to work with older clients to maintain or regain a higher level of independence. |

# Impact and affordability of Support Worker wages being paid on the basis of the required levels of training of the worker

| **Area** | **Key observations** |
| --- | --- |
| In-between Travel Settlement Agreement | The parties to the Settlement Agreement agreed to explore the impact and affordability of Support Worker wages being paid on the basis of the required levels of training of the worker as part of regularising the home and community support workforce.  The impacts of Support Worker wages being paid on the basis of the required levels of training within an attractive remuneration framework comparable to other workforces applying similar levels of skill, knowledge and expertise include:  1. incentivising workforce development and career planning  2. increasing the visibility of workforce skill levels, improving Support Workers perceived status and value  3. addressing ongoing significant recruitment and retention pressures  4. aligning the value of the workforce with the value of the service the workforce provides in delivering home and community support services to older and disabled clients.  One caveat is that:   * Funding levels must be sufficient and regularly reviewed to ensure that providers can sustain the ongoing cost of maintaining wage differentials based on training. |
| Current state | Generally there is no specific recognition of training or qualifications in Support Worker wages, and most Support Workers are paid at or close to the Minimum Wage, irrespective of any qualification they have. Providers who have introduced some recognition of skill differentials in wage rates report that differentials are rapidly eroded through unfunded increases in statutory minima (the Minimum Wage, Kiwisaver contributions and ACC rates). Based on information from the Ministry of Health 2015 Workforce Survey, the increase in the Minimum Wage from $14.25 per hour to $14.75 per hour improved or matched the existing pay rate of 43% of the workforce.  The Ministry of Health 2015 workforce survey shows that the HCSS workforce is becoming qualified but continues to be paid at or close to the Minimum Wage. Thirty-one providers covering 4913 Support Workers (20% of the workforce) provided information on Support Worker wage rates and qualifications. |
| Current state (continued) | Figure 1: Percentage of Home and Community Support Workers with a recorded qualification, by hourly rate |
| Qualification framework | The sector has worked closely with the ITO Careerforce to develop the New Zealand Health and Wellbeing qualification framework.[[9]](#footnote-9) This is the only measure of the required levels of support-worker training that is objective, transparent and able to be consistently applied across the sector. Three levels of support-worker skills, knowledge and expertise are recognised, with New Zealand Qualifications Authority certificates creating a career path towards attaining higher-level, more specialised qualifications.  The three qualification levels recognise differences in the levels of support that clients may require. Level 2 recognises proficiency in the provision of person-centred support; Level 3, Health Assistance, recognises the skills and knowledge required to support and empower people in their home; and Level 4[[10]](#footnote-10) recognises expertise in advance support work, spinal injury support, or traumatic brain injury support.  Anecdotally, staff turnover rates are between 20 and 40%, and the average tenure is 3.3 years. Providers report that higher starting rates of pay in roles that require similar levels of skills, knowledge and expertise available in other industries create recruitment and retention pressures. Recruitment and retention pressures reduce when entry rates, opportunities for pay increases and career development opportunities are comparable with other workforces applying similar skills, knowledge and expertise and providing comparable services. |
| Potential remuneration framework | Within the health sector, DHB entry rates for comparable workforces are generally between $1 and $2.50 above the Minimum Wage and provide between $0.75 and $1.20 wage-step increases that recognise differences in performance, skills or qualifications. Increases are annual up to a maximum rate payable. The comparable turnover rates in DHBs are around 10% per annum.  The joint DHBs/industry cost and pricing tool was used to assess the effect of moving the support-worker workforce to a remuneration framework comparable to that of a similar DHB-employed workforce. The cost implications are illustrated below.  Table 2: Cost implications of wages linked to qualifications   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Step increase** | **$1 above Minimum Wage** | | **$2.50 above Minimum Wage** | | | **$0.75** (comparable to DHB Home Aides) | **$1.20** | **$0.75** | **$1.20** (comparable to DHB Health Care Assistants) | | No qualification rate | $15.75 | $15.75 | $17.25 | $17.25 | | Level 2 Certificate rate | $16.50 | $16.95 | $18.00 | $18.45 | | Level 3 Certificate rate | $17.25 | $18.15 | $18.75 | $19.65 | | Level 4 Certificate rate | $18.00 | $19.35 | $19.50 | $20.85 | | Increase in baseline cost | 5.87% | 8.53% | 11.57% | 14.6% |   Notes  The increase in baseline costs of Support Worker wages being paid on the basis of the required levels of training under the remuneration framework(s) in Table 2 above has been estimated using the price/cost model in Appendix 1.  National qualification rates are assumed to be consistent with the Ministry of Health 2015 Workforce Survey results (see Figure 2 below).  The assumption is that increase in baseline cost is from a baseline that has all Support Workers paid at $15.00 per hour, which is the median rate calculated from the Ministry of Health 2015 Workforce Survey. |
| Comparative health sector wage rates | The HCSS providers, DHBs and unions consider the DHB-employed Health Care Assistant workforce provides a comparable service to Support Workers and applies very similar skills, knowledge and expertise. Due to the isolation and lack of support and supervision, the demands on home Support Workers is much greater. The three parties consider that support-worker wage rates need to be aligned to the DHB-employed Health Care Assistant role in order to attract and retain a high-quality workforce on an ongoing basis. This is consistent with the recommendation of the Human Rights Commission in the 2012 report on equal employment opportunities in the aged care sector, *Caring Counts*.[[11]](#footnote-11)  Current rates paid to DHB-employed Health Care Assistants range from $17.02 to $19.65 gross per hour over a four-step scale that does not have a requirement to hold a qualification to progress. These rates closely align with a support-worker remuneration framework with an entry rate at $2.50 above the Minimum Wage and step increases of $1.20 over four steps.  DHB-employed home aides have similar roles to Support Workers. Rates paid range from $15.48 to $18.15 gross per hour over six steps linked to the level of qualification held. These rates closely align with a Support Worker remuneration framework with an entry rate at $1.00 above the Minimum Wage with no qualifications and step increases of $0.75 over four steps.  The unions consider the DHB-employed home aide workforce applies skills, knowledge and expertise comparable to those of the DHB-employed Health Care Assistants. It advises that it has sought parity in rates over successive bargaining processes. The workforce is small, and the union contends that wage rates are principally driven by the larger orderly, cleaning and kitchen/laundry workforces, and the move by all but a handful of rural DHBs to exit their in-house services in favour of the work being taken over by providers contracted to the DHB funder arms.  The providers and unions both consider a support-worker remuneration framework closely aligned to rates paid to DHB-employed home aides is not high enough to address recruitment and retention pressures on an ongoing basis. Both cite the DHB-employed Health Care Assistant role as the main health sector source of recruitment and retention pressures. Providers report that many of their most skilled and valued Support Workers leave at the first opportunity to move into these higher-paying roles.  The unions have a pay equity proposal that uses an independently developed gender-neutral job evaluation of the Support Worker role to demonstrate that Support Worker skills, knowledge and expertise closely align with those of correction officer roles. Current Correction Officer rates range from $23.33 to $28.73 gross per hour over four steps linked to the level of qualification held. |

# Impact and affordability of providing paid training time to enable Support Workers to obtain Level 3 New Zealand Certificate qualifications

| **Area** | **Key observations** |
| --- | --- |
| Background | In 2011 the Auditor-General noted in the *Report on Home-based Services for Older People* that Support Workers were generally viewed as unskilled, and that better levels of training are required to develop staff and ensure they are able to provide the increasingly complex level of home and community support services that older people need. In a 2014 review of progress, the Auditor-General commented that the Ministry of Health and DHBs had made some progress in strengthening management contracts as a way of ensuring service providers’ staff are adequately trained and supervised.  Since 2011 the sector has worked closely with the sector Industry Training Organisation Careerforce to develop the New Zealand Health and Wellbeing qualification framework. This New Zealand Qualification Authority-recognised framework comprises the:  1. New Zealand Health and Wellbeing Level 2 certificate, recognising proficiency in the provision of person-centred support  2. New Zealand Health and Wellbeing Level 3 certificate, recognising the skills and knowledge required to support and empower people in their home or community setting  3. New Zealand Health and Wellbeing Level 4 certificate, recognising expertise in one of three specialist areas of care: spinal injury, traumatic brain injury or advanced support work.  See Appendix 2 for detailed information about the content of Level 2 and Level 3 qualifications.  Learning and assessment occur in the workplace, with support from providers. In general, funding is linked to service provision, and providers are not funded for time spent training or the costs of support, classroom training, verification and ITO costs. The workforce and the majority of Support Workers are not paid for their time being trained. The current model of self-directed learning takes the average Support Worker 18 months to two years to complete. Well under 50% of Support Workers are currently offered the opportunity to complete formal qualifications. Low rates of qualified Support Workers affect providers’ ability to arrange travel rosters efficiently and to meet increasing demand for high-end care cases.  Over the past five years the number of Support Workers achieving qualifications and the level of achievement has grown. In 2012 ACC introduced a requirement for specific worker qualification into contracts with lead suppliers, with the specific intention of increasing workforce skill level. This and any future investment in training will contribute to a training culture within the sector.  The Ministry of Health 2015 Workforce Survey shows that the home and community support-worker workforce is becoming increasingly more qualified, although the overall percentages are still low. Thirty-two providers covering 8324 Support Workers (34.6% of the estimated 24,000 support-worker workforce) provided information on workforce qualifications (see Figure 2 and Table 3). |
| Background (continued) | Figure 2: Percentage of Home and Community Support Workers with a recorded qualification  Source: Ministry of Health 2015 Home and Community Support Service Workforce Survey  Table 3: Number of Home and Community Support Workers with a recorded qualification, by employer size   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Employer size** | **None** | **On the job** | **New Zealand Qualifications Authority** | | | **Graduate/ postgrad** | **Other** | **Total** | | **Level 2** | **Level 3** | **Certificate** | | 1−50 | 0 | 84 (39%) | 33 (15%) | 17 (8%) | 5 (2%) | 2 (1%) | 72 (34%) | 213 (100%) | | 51−100 | 36 (7%) | 269 (54%) | 78 (16%) | 89 (18% | 11 (2%) | 8 (2%) | 5 (1%) | 496 (100%) | | 101−200 | 108 (14%) | 100 (13%) | 272 (35%) | 266 (34%) | 19 (2%) | 16 (2%) | 2 (0%) | 783 (100% | | 201−300 | 134 (25%) | 132 (24%) | 92 (17%) | 16 (3%) | 1 (0%) | 10 (2%) | 154 (29%) | 537 (100%) | | 301−600 | 0 | 511 (42%) | 335 (27%) | 337 (28%) | 38 (3%) | 1 (0%) | 1 (0%) | 1223 (100%) | | 1501+\* | 0 | 1742 (34%) | 1919 (38%) | 1281 (24%) | 128 (2%) | 0 | 0 | 5070 (100% | | Total | 278 (3%) | 2838 (34%) | 2729 (33%) | 2006 (24%) | 202 (2%) | 37 (0%) | 234 (3%) | 8324 (100%) |   Source: Ministry of Health 2015 Home and Community Support Service Workforce Survey  \* There are no or very few employers who have between 601 and 1,500 employees in 2015. |
| In-between Travel Settlement Agreement | The parties to the Settlement Agreement agreed to explore the impact and affordability of providing paid training time to enable Support Workers to obtain the Level 3 New Zealand Certificate qualification within two years of Support Worker commencing work, in line with the service needs of the population as part of regularising the home and community support workforce.  The implications of providing workers with paid training time are that:  1. funding levels need to be sufficient to ensure providers can sustain the ongoing cost of a proportion of the workforce being paid for time that is not generating revenue  2. the ‘hours of work’ definition in Support Workers’ employment agreements needs to include time rostered to attend required training. |
| Impact and affordability | The average cost to train a Support Worker has been estimated as follows.  Table 4: Training Costs for Level 2 and Level 3 Certificate per Support Worker   |  |  |  | | --- | --- | --- | | **Qualification** | **Average per Support Worker** | | | **Training Time** | **Cost** | | New Zealand Health and Wellbeing Level 2 Certificate | 2−9 hours | $647 | | New Zealand Health and Wellbeing Level 3 Certificate | 30 hours | $1403 |   The model that was used to determine the average time and cost to train a support worker to obtain the Level 2 and 3 qualifications has been reviewed by Careerforce and is considered by the union, DHB and provider representatives to be fair, reasonable and practicable. The assumptions are that:  1. all Support Workers will gain the Level 2 qualification as part of their pathway to the Level 3 qualification to address literacy and numeracy skill levels and provide the confidence for Support Workers to achieve academically  2. providers will continue to internally assess workers against the qualification requirements and Support Workers to achieve qualifications  3. the average time includes consideration of any additional literacy support that may be required for an individual Support Worker.  The positive impacts of paid training are expected to be:  1. higher levels of confidence on the part of Support Workers − more skilled, better valued  2. for the funder, confidence that the Support Worker is the right person to deliver care to a client  3. for the provider, a reduction in risk to the quality of services, and an ability to acknowledge the value of the worker  4. for the client, a better standard of care.  The cost implications of providing paid training time to enable the Support Worker workforce to obtain the Level 3 New Zealand Certificate qualification has been estimated at 1.17% of current baseline costs using the price/cost model in Appendix 1. |

# Impact and affordability of the majority of workers being employed on guaranteed hours

| **Area** | **Key observations** |
| --- | --- |
| In-between Travel Settlement Agreement | The parties to the Settlement Agreement agreed to explore the impact and affordability of moving to an employment model where the majority of Support Workers are employed on guaranteed hours. The impacts of moving to such an employment model Support Worker include:  1. easing the ongoing significant recruitment and retention pressures through certainty of work (and income)  2. continued employment of a flexible, casualised workforce available to respond to workload fluctuations  3. potentially reduced flexibility for Support Workers and clients to agree to deviate from rostered service delivery times at short notice in order to accommodate unplanned events, depending on rostering and organisational practices  4. the risk of less client choice of time of service delivery, and of Support Worker, as providers seek to optimise their rostering practices to reduce travel costs and increase efficiencies.  [Mitigation strategies could include setting up a cluster of Support Workers working as a team within a defined geographical area and supporting a common group of clients. This would mean quality care is delivered to each client, but not always by the same person and within a time range. The team-based approach requires sufficient numbers of qualified staff as well as a change in service expectations.]  5. avoiding the need for Support Workers to work more than one job, or rely on alternative income  6. minimising the potential legal risk that follows from a union view that not providing ongoing work/employment when work patterns may suggest that employment is of a more permanent nature and the provider has an ongoing contract to provide services.  The caveats include:  1. funding levels being sufficient to mitigate the financial risk to providers of guaranteeing a Support Worker a set number of paid hours of work when there is no guarantee that work is available for that Support Worker to do  2. acceptance across the sector that flexibility to vary from rostered services to accommodate unplanned events is likely to be reduced  3. Support Worker employment agreements clearly outlining employment definitions aligned to the Employment Relations Act 2000 and provisions relating to the administration of guaranteed hours of work. |
| Current state | Generally, the hours worked by Support Workers are based on the assigned client’s needs and remunerated on a piecemeal basis (ie, payment is per client hour), with no guaranteed hours of work or workloads. While rosters are developed (generally up to a fortnight in advance of service delivery), Support Workers and clients sometimes agree to vary from the roster to accommodate unplanned events.  The needs of clients fluctuate and workloads are affected when an assigned client is on holiday, in hospital, enters residential care or no longer requires the service. In addition, some clients only need services on a short-term basis. The degree of variability in client need and funding linked to service provision is regularly cited as the rationale for Support Worker hours not being guaranteed.  The Ministry of Health 2015 Workforce Survey asked providers to provide the hours worked by each employee in each week over a four-week period (8 February to 9 March 2015). Thirty-one providers, covering 4913 workers (20% of the estimated workforce), provided the information requested (see Figure 3 and Table 5). |
| Current state (continued) | Figure 3: Percentage of Home and Community Support Workers who worked consistent hours for the period 8 February to 9 March 2015  Source: Ministry of Health 2015 Home and Community Support Service Workforce Survey  Notes  1. Workers were deemed to have consistent hours if the number of hours worked each week varied by less than 5%.  2. The survey did not collect information on consistency of actual hours or days worked. |
| Current state (continued) | Table 5: Number of Home and Community Support Workers who worked consistent hours, by employer size, for the period 8 February to 9 March 2015   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Employer size** | **No consistency** | **2 weeks** | **3 weeks** | **4 weeks** | **Total** | | 1−50 | 18 (8%) | 75 (35%) | 29 (14%) | 90 (43%) | 212 (100%) | | 51−100 | 72 (15%) | 196 (40%) | 65 (13%) | 162 (33%) | 496 (100%) | | 101−200 | 163 (21%) | 289 (37%) | 199 (25%) | 133 (17%) | 783 (100%) | | 201−300 | 63 (12%) | 185 (34%) | 112 (21%) | 177 (33%) | 537 (100%) | | 301−600 | 335 (27%) | 586 (48%) | 201 (16%) | 101 (8%) | 1222 (100%) | | 1501+\* | 386 (23%) | 678 (41%) | 354 (21%) | 246  (15%) | 1664 (100%) | | Totals | 1036 (21%) | 2008 (41%) | 960 (20%) | 909 (19%) | 4913 (100%) |   Source: Ministry of Health 2015 Home and Community Support Service Workforce Survey  \* There are no, or very few employers that have between 601 and 1500 employers in 2015. |
| Union perspective | The unions acknowledge the variability in client need and the impact of funding linked to service provision, but consider that an unknown but significant proportion of Support Workers have regular and consistent work patterns, suggesting a high percentage of the workforce can be employed with ongoing guaranteed hours of work.  The unions consider that the fewer the number of Support Workers who have guaranteed hours and the smaller the percentage of hours guaranteed, the greater the risk that a Support Worker’s rights under the Employment Relations Act to an ongoing expectation of work and good faith consultation (in regard to changes in hours of work) are being breached. The unions consider that an ongoing risk will remain for any Support Worker who is not specifically employed on a casual or fixed-term basis and whose work pattern is not consistent with that employment arrangement (as defined in the Employment Relations Act and case law).  The unions acknowledge that in many circumstances it is not appropriate for Support Workers to vary from rostered clients and service delivery times; for example, where clients require medication or require support in order to be ready to start work at a specific time. However, the unions also consider that with teams of Support Workers, where possible in less critical situations, Support Workers and their clients could maintain some flexibility to vary rosters to accommodate unplanned events. |
| Provider perspective | In general, providers favour a high percentage of the workforce having regular, ongoing guaranteed hours of work. The providers expect that guaranteeing a percentage of the Support Worker hours will generate efficiencies in training, rostering, administration and ability to meet unplanned immediate client need, and may increase the average hours worked per Support Worker (currently 21 hours per week).  The providers note that the financial implications of being required to pay Support Workers for time spent travelling between clients (from 1 July 2015) and reimbursing a proportion of travelling costs (from 1 March 2016) will have a significant impact on Support Workers’ ability to vary from rostered times and clients. In general, providers do not support rosters being changed without their knowledge and agreement (for health and safety, service quality, administrative and efficiency reasons).  The providers consider that the higher the number of Support Workers who have guaranteed hours and the higher the percentage of hours guaranteed, the greater the potential financial risk of being required to pay a Support Worker, irrespective of whether or not the hours guaranteed have been worked (and therefore have generated revenue).  The providers propose that the financial risk of increasing the percentage of Support Workers being employed on guaranteed hours be recognised specifically in the price/cost model recommended for use in provider−DHB contract negotiations (set at present at a nominal level of 3%, which is subject to change), and that the price/cost model be used as the basis of negotiations between DHBs and providers. |
| Agreed approach to measurement | In discussions, provider and union representatives agreed that a transition to guaranteed hours would be required, as follows.  1. Implementing the In-between Travel Settlement Agreement would require at least 51% of Support Workers being employed on guaranteed hours within 12 months of implementation.  2. The model for measuring implementation would involve three variables:  i) a minimum of 51% of the provider’s total workforce is to have guaranteed hours (ie, the number of Support Workers with guaranteed hours is a function of the provider’s total workforce and is not limited to a proportion of the permanent workforce), which is to ensure the intent of the In-between Travel Settlement Agreement is adhered to in that a majority of Support Workers will have guaranteed hours  ii) each Support Worker with guaranteed hours will have had their last three months of hours reviewed and the hours deemed to be permanent will make up the number of hours guaranteed, to a maximum of 40 hours per week  iii) a minimum of 51% of the provider’s contracted hours are to be guaranteed (which minimises the risk of the provider guaranteeing hours to the Support Workers with the least number of regular hours in order to comply).  3. Transition to guaranteed hours, as set out in clause ii above, will depend on the allocation of appropriate funding based on the analysis of non-utilisation rates and other factors (eg, turnover of clients and staff).  4. A move towards 80% of Support Workers being employed on guaranteed hours is considered to be a realistic goal for the majority of providers to work towards over the three-year period (which will result in a core workforce working regular, guaranteed hours, supported by a casualised/fixed-term workforce to assist in dealing with variability in client volume and need. |
| Implications of the introduction of guaranteed hours | The provider view is that:  1. funding levels need to be sufficient to mitigate their ongoing financial risk of paying for non-utilised or non-revenue-generating Support Worker time  2. the price/cost model should include a percentage to recognise the financial risk of increasing the percentage of Support Workers being employed on guaranteed hours (currently set at a nominal rate of 3%), to be subject to further investigation.  The cost implications of moving to an employment model where at least 51% of Support Workers are employed on guaranteed hours has been estimated at a nominal 3% of current baseline costs and has been factored into the price/cost model Appendix 1.  Note: Australian reports indicate that the cost implications may increase up to an estimated 20% when 80% of Support Workers are employed on guaranteed hours, in recognition of the increased risk that providers will be required to pay staff for non-utilised or non-revenue-generating time. The rate is also influenced by the degree of client choice of Support Worker and/or time of service delivery factored into service delivery models. |

# A case-load and case-mix workload mechanism to ensure a fair and safe allocation of clients to Support Workers

| **Area** | **Key observations** |
| --- | --- |
| Goal | The parties to the Settlement Agreement agreed to explore the impact and affordability of moving to a case-mix and case-load mechanism to ensure fair and safe client allocation at a safe staffing level. |
| Principles guiding workload allocation | A system of workload allocation for home Support Workers should:   * be fair and objective, and minimise the opportunities for favouritism * support the health and safety of both staff and clients * enable Support Workers to know as far in advance as is practicable what their workload is and what clients they are supporting * reflect career development pathways (including specialisation where applicable), with workloads that acknowledge the stage of development of the worker * match worker skill levels to client needs * allocate realistic and manageable timeframes for each client visit, consistent with funding arrangements and service agreements * allocate realistic and manageable timeframes to cover travel time (as it is described in the In-between Travel Act) and break times, consistent with funding arrangements * create efficiencies by minimising travel (except where client needs for a particular Support Worker competency require otherwise). |
| Proposed intended outcomes | In order to give effect to these principles the following is required.  1. There should be fair distribution of both complex and non-complex tasks to all home Support Workers. For ‘package of care’ clients (ie, clients who receive a package of HCSS services to meet both their non-complex and complex care needs), all assignments contributing to this client should be allocated as a package to the one Support Worker, where practicable, or to the team working around that client.  2. Support Workers new to the sector should be allocated non-complex tasks until qualified to complete more complex tasks.  3. A time allowance of 0.5 hours per week per Support Worker has been factored into the price/cost model as non-revenue-generating time to allow the opportunity for providers to provide additional workforce support through regular team meetings, ongoing access to supervision, quality and peer review meetings, and mentoring arrangements for inexperienced staff. This cost (along with the 3% [nominal] cost of guaranteeing hours to 51% of the workforce) is shown in the ‘Additional SW Costs’ column of the price/cost model in Appendix 1.  Union representatives see merit in providers allocating to experienced Support Workers a mixture of non-complex and complex tasks to minimise fatigue, reduce the number of Support Workers going into a client’s home, and create efficiencies in relation to travel time.  Providers consider that high standards of care can be provided in a variety of ways; for example, telephone checks on clients to ensure they are taking their medication, the delivery of complex care by suitably qualified staff, and household support from less qualified staff, as necessary. |
| Case mix | Under the case-mix model, nationally agreed minimum safety and service standards and worker competency criteria can be established for each case-mix category. Suitably qualified Support Workers are allocated according to the objectively assessed health care needs and a case-weighted determination of the number of hours required to meet those needs.  Using the case-mix model, the care needs of a client over the age of 65 are determined using the InterRai assessment tool. InterRAI is designed to identify an older person’s medical, rehabilitation and support needs. An InterRAI assessment covers a number of factors, including mobility and self-care. It results in a package of care for each person and the assignment of a case-mix category reflecting the required level of care.  For example, in the non-complex category, Category 3a refers to clients whose condition is stable. Using a case-weighted approach, these clients require fewer hours of care. A client with significant rehabilitation requirements will fall into Category 8, the highest category of complex care, requiring more hours of care delivered by a suitably qualified and skilled Support Worker.  Provider hours can then be allocated according to the case-weighted number of the hours required for each category of client. Although a smaller proportion of home- and community-based clients have complex care needs, providers need to allocate a higher number of hours to their care.  In summary, the case-mix model is more efficient because provider hours are allocated according to an objective determination of a client’s health care needs. Also, there is a decrease in service hours inherent in the case-mix model, which will produce cost savings due to a decrease in bed days and emergency department admissions.  Under the case-mix model, only 35% of assessments (the complex cases) are completed by the NASC service. The provider completes the rest. In line with a restorative model of care, annual reviews of clients are undertaken and Support Workers are encouraged to communicate changing levels of client need to the provider. There is no disincentive to do this, because pay is not linked to time spent with each client. |

# Structuring future service delivery

| **Area** | **Key observations** |
| --- | --- |
| Changes needed to sustain a regularised workforce and fit-for – purpose HCSS | The transition to a regularised workforce must be supported by a number of infrastructural changes, without which the sustainability of HCSS will continue to be at risk. Nor will the sector be well placed to meet the increasingly complex care requirements of the anticipated number of clients seeking home- and community-based care in future.  The proposed changes are to:  1. funding arrangements, so that the price paid by the funder to the provider:   * reflects the cost of delivering the service * is based on a consistent price/cost model (use of the 2014 Price/Cost model set out in Appendix 1 is recommended) * is reviewed on an annual basis to take into account statutory minima requirements   2. the contract model relevant to engagement between funders and providers  3. service specifications.  Addressing the current variability in funding models and service delivery models through a national contract, national quality standards (service specifications) and a national costing methodology will reduce back-office effort, improve efficiency and reduce the total market cost of procurement processes. It will also remove regional differences that don’t improve performance and remove the need for providers to maintain multiple models. |
| Funding arrangements | The price paid by funders to providers needs to reflect an objective assessment of the costs of delivering the services, as determined through the price/cost model.  The price paid needs to be subject to review on an annual basis to take into account any increase in statutory minimums. These arrangements are fundamental to the successful regularisation of the workforce and the ongoing sustainability of services.  A national contracting arrangement similar to the Aged Residential Care Contract is recommended as a basis for a consistent service delivery model and common funding approach across the DHBs. |
| Objective of the funding methodology | The objective of a nationally consistent service delivery model is to provide appropriately funded, safe, effective and cost-efficient home and community support services via a model whereby both the DHBs and providers assume risks over which they have control, and can therefore influence the cost inputs.  Case mix is a model widely supported by the provider sector. Under such a model, the allocation of risk is related to the matters over which the parties exercise control. Providers are responsible for the delivery of safe (safety), efficient and cost-effective operations (efficiency), and DHBs for the impact of their decisions on both service entry and ‘related services’ that affect home support service levels (volume).  Under case mix, nationally agreed minimum safety and service standards and worker competency criteria are established for each case-mix category. Funding is then based on agreed national average inputs per case-mix category. Each client is allocated a package of care based on their InterRAI-assessed case-mix category. Case-mix category funding is based on the agreed national average inputs (with nationally agreed maximum inputs per case-mix category) calculated at the agreed national pricing level.  Clients requiring services above the nationally agreed maximum inputs per case mix are agreed between the parties and funded on a fee-for-service’ basis.  Although a national InterRAI assessment process ensures a national consistency of assessment, it requires a national contracting framework to ensure national consistency in the client service response to that assessed need. Having nationally agreed minimum safe and average funded inputs for each case-mix category provides assurance that clients will receive a consistent, safe service irrespective of their location in New Zealand. |
| Benefits of the recommended case-mix approach under a national framework | DHBs retain flexibility in that:  1. the case-mix model will automatically reflect individual DHB client demographic mix  2. they can transparently target services, by case-mix category, to assist in meeting other DHB priorities (eg, residential bed numbers) and budgetary considerations; for example, they may decide not to deliver some lower-level non-complex categories if it was deemed that this would not adversely affect other DHB services  3. the funding methodology, with pricing based on case-mix average inputs, would retain the flexibility to be addressed on an individual client fee-for-service, client package of care, or bulk-funded model. |
| Quality standards and service standards | The support-worker workforce is unlike comparable workforces working in DHB or residential settings in that they have no immediate access to support and advice from experienced co-workers, or nursing or medical staff. Quality standards that align policy and quality, employment and training, and service delivery are required to provide a framework for the management of the risks associated with home-based care. |

# Appendix 1: Costing and pricing model

| **Area** | **Key observations** |
| --- | --- |
| Costing and pricing model | The assumptions in the costing template were updated to reflect current rates and sections added to the tool to incorporate other elements that need to be accommodated. The tool was then used to model the cost and pricing scenarios flowing from the Settlement Agreement. The following sections were revised or added:  **Travel** |
| To reflect the In-between Travel Settlement Agreement, the average travel distance of 4.45 km is reimbursed at $0.50 cents per kilometre, and a time allowance of 11.2 minutes is added. This is fully funded through Settlement Agreement funding.  **Training** |
| Training costs are factored into the model. Costs to back-fill paid training time are not included because these would be covered by the employer within the costing/pricing model.  **Additional Support Worker Costs** |
| Regularising the workforce with guaranteed hours requires the employees to be flexible and for them to be informed. The model allows for 1.25% (two hours per month) paid meeting time, for quality improvement and client peer review discussions.  In addition, an allowance of 3% is added in recognition that there will be time when client hours change to reduce employee utilisation before changes can be reflected in the guaranteed hours.  **Differential for Qualifications** |
| The model allows for stepped wage rates along with the proportionate staff mix per step. To model the costs of moving to paid training and guaranteed hours, a $0.75 differential was used between steps, and the minimum wage as the entry level.  Industry average values were used as the default value for overheads. Actual values were used where known. A 6% return on investment (margin) is used.  **Scenario Modelling** |
| Using the tool to model the cost and pricing scenarios flowing from the Settlement Agreement provides indicative increases to the baseline costs, as measured after paid travel has been factored in.  **Basis Cost/Price** |
| Zero values for travel, additional support-worker costs, training or differential for qualifications.  **Baseline for Costing** |
| Agreed values from the Settlement Agreement were added for in-between travel to set the starting point for measuring the effect of introducing the new provisions. |



| **Area** | **Key observations** |
| --- | --- |
| Explanation of Cost and Price Modelling Scenarios | The following provides explanation of elements of the Cost and Price Modelling Scenarios table (previous page):   * adding the additional support-worker costs arising from guaranteed hours adds 2.49% to the price * adding paid training costs and time adds 1.17% to the price * adding a differential for attaining qualifications at Level 2 and Level 3 adds 1.6% to the price * the cumulative increases amount to 5.35% to the price * the basic cost/price-level price exceeds the price some DHBs currently pay prior to the In-between Settlement Agreement, and there is current variability in how DHBs fund services * the methodology applied requires peer review and further discussion with stakeholders if it is to form the basis of future funding decisions. |

# Appendix 2: Programme structure

## Level 2 qualification

|  |  |  |  |
| --- | --- | --- | --- |
| **Outcome** | **Unit standards** | **Level** | **Credit** |
| **1. Work within the responsibilities and boundaries of own role** | **Compulsory:** | | |
| 23451 Describe the role of a Support Worker in a health or wellbeing setting | 2 | 5 |
| **Optional:** | | |
| 23686 Describe a person’s rights in a health or wellbeing setting | 2 | 1 |
| **2. Perform entry-level person-centred tasks and functions in a health or wellbeing setting** | **Compulsory:** | | |
| 28519 Maintain a safe and secure environment for people and Support Workers in a health or wellbeing setting | 2 | 6 |
| 28529 Identify the impact of culture on support in a health or wellbeing setting | 2 | 5 |
| **Minimum of 14 credits selected from the following:** | | |
| 23386 Support a person to meet personal care needs in a health or wellbeing setting | 3 | 5 |
| 28545 Apply personal plan requirements to meet the needs of people in a health or wellbeing setting | 2 | 5 |
| 20826 Describe infection control requirements in a health or wellbeing setting | 2 | 3 |
| 23452 Describe the principles for moving equipment and people in a health or wellbeing setting | 2 | 3 |
| 23685 Describe pre-packaged medication and the process for its use in a health or wellbeing setting | 2 | 2 |
| 26978 Support a person to eat and drink in a health or wellbeing setting | 2 | 4 |
| 26979 Describe the immediate response to the death of a person in a health or wellbeing setting | 2 | 2 |
| 28546 Describe incontinence and interventions to assist a person in a health or wellbeing setting | 3 | 5 |
| 28548 Support a person’s wellbeing and quality of life in a health or wellbeing setting | 2 | 3 |
| **3. Recognise and report risks and/or changes in a person and/or family/whānau** | **Compulsory:** | | |
| 28517 Recognise and report risks and changes for a person in a health or wellbeing setting | 2 | 5 |
| **4. Communicate to support a person’s health or wellbeing** | **Compulsory:** | | |
| 28518 Interact with people to provide support in a health or wellbeing setting | 2 | 5 |

## Level 3 qualification

| **Outcome** | **Unit standards** | **Level** | **Credit** |
| --- | --- | --- | --- |
| 1. Recognise and respond to signs of vulnerability and abuse in a health or wellbeing setting | **Compulsory:** | | |
| 28521 Recognise and describe responses to vulnerability and abuse in a health and wellbeing setting | 3 | 5 |
| 2. Demonstrate ethical and professional behaviour in a health or wellbeing setting | **Compulsory:** | | |
| 28542 Demonstrate and apply knowledge of professional and ethical behaviour in a health or wellbeing setting | 3 | 5 |
| 3. Provide person-centred support to maximise independence | **Minimum of 56 credits from the following:** | | |
| 1810 Provide information about resources and support services in a health and wellbeing setting | 3 | 2 |
| 1818 Describe the value of relationships in people’s lives in a health or wellbeing setting | 3 | 3 |
| 1828 Identify services available to people with disabilities | 3 | 4 |
| 9694 Demonstrate and apply knowledge of communication process theory | 3 | 5 |
| 16870 Describe intellectual disability and the support needs of a person with an intellectual disability | 3 | 4 |
| 16871 Describe physical disability and the support needs of a person with a physical disability | 3 | 4 |
| 20827 Support a person to use prescribed medication in a health or wellbeing setting | 3 | 3 |
| 20965 Describe epilepsy and the support needs of a person with epilepsy in a health or wellbeing setting | 3 | 4 |
| 23371 Support personal planning to enhance individual lifestyles with a person with disability | 3 | 5 |
| 23372 Describe law in relation to intellectual disability and high and complex needs and legal services available to people | 3 | 3 |
| 23374 Describe autism spectrum disorders (ASD) and support strategies | 3 | 3 |
| 23375 Describe hearing impairment | 3 | 5 |
| 23377 Use visual strategies for communicating with Deaf and hearing impaired people | 3 | 3 |
| 23382 Support a person to participate as a member of the community in a health or wellbeing setting | 3 | 3 |
| 23385 Demonstrate knowledge of advocacy and self-advocacy in a health or wellbeing setting | 3 | 4 |
| 23386 Support a person to meet personal care needs in a health or wellbeing setting | 3 | 5 |
| 23387 Demonstrate the ageing process and its effects on a person’s lifestyle and wellbeing | 3 | 7 |
| 23388 Provide support to a person whose behaviour presents challenges in a health or wellbeing setting | 3 | 4 |
| 23389 Describe risk management planning in a health or wellbeing setting | 3 | 3 |
| 23391 Respond to loss and grief in a health or wellbeing setting | 3 | 2 |
| 23925 Support, mentor, and facilitate a person to maximise independence in a health or wellbeing setting | 3 | 6 |
| 24895 Describe the visual system and vision impairment | 3 | 5 |
| 3. Provide person-centred support to maximise independence (continued) | 25987 Describe culturally safe principles and Pacific values for people in a health or wellbeing setting | 3 | 6 |
| 26801 Describe the benefits of breastfeeding, available support services, and Baby Friendly Initiatives | 3 | 3 |
| 26802 Describe information, interactions, and strategies to protect, promote and support breastfeeding | 3 | 3 |
| 26971 Describe factors that contribute to mental health wellbeing and mental health problems | 3 | 3 |
| 26974 Describe interaction, supports and reporting for people with dementia in a health or wellbeing setting | 3 | 8 |
| 26977 Move a person using equipment and care for equipment in a health or wellbeing setting | 3 | 4 |
| 26980 Provide comfort cares, and report changes in the condition of a person with a life-limiting condition | 3 | 3 |
| 26981 Describe risks, impacts and actions for falls and minimise risk of falls in a health or wellbeing setting | 3 | 3 |
| 27455 Conduct nutrition screening with, and provide education to, adult clients in an aged care, health or disability context | 4 | 6 |
| 27457 Describe the anatomy and physiology of systems and associated organs of the human body | 3 | 6 |
| 27458 Support a person to develop and achieve goals in a health or wellbeing setting | 3 | 3 |
| 27460 Describe a person’s nutritional requirements and feeding issues in a health or wellbeing setting | 3 | 3 |
| 27461 Describe indicators of wellness, interventions, care and support for people at different human lifespan stages | 3 | 5 |
| 27468 Apply safe swallowing strategies in a health or wellbeing setting | 3 | 5 |
| 27504 Describe tobacco use and dependence and smoking cessation treatments | 3 | 5 |
| 27505 Assess a person for tobacco dependence and support a person to develop a stop-smoking plan | 3 | 6 |
| 27506 Support a person to implement a stop-smoking plan and provide ongoing support to assist a person to remain smoke free | 3 | 6 |
| 27507 Describe tobacco control and health promotion as ways of enhancing health through smoking cessation | 3 | 5 |
| 27833 Support people to use assistive equipment and move in a health or wellbeing setting | 3 | 5 |
| 28520 Demonstrate knowledge of specific conditions and their impacts when providing support in a health or wellbeing setting | 3 | 9 |
| 28523 Describe community values and attitudes and their impact on people with disabilities | 3 | 2 |
| 28524 Describe a person’s holistic needs and their impact on a person’s health and wellbeing | 3 | 5 |
| 28528 Describe and apply a person-centred approach in a health and wellbeing setting | 3 | 3 |
| 28535 Demonstrate knowledge of procedures for infection control in a health and wellbeing setting | 3 | 4 |
| 28536 Apply health, safety and security practices in a health or wellbeing setting | 3 | 5 |
| 28543 Describe culturally safe Māori operating principles and values, and their application in a health or wellbeing setting | 3 | 5 |
| 28544 Provide support to people from different cultures in a health or wellbeing setting | 3 | 5 |
| 3. Provide person-centred support to maximise independence (continued) | 28546 Describe incontinence and interventions to assist a person in a health or wellbeing setting | 3 | 5 |
| 28547 Support a person with diabetes in a health or wellbeing setting | 3 | 3 |
| 28550 Support a person with chronic obstructive pulmonary disease (COPD) in a health or wellbeing setting | 3 | 3 |
| 28557 Communicate to support people’s health and wellbeing | 3 | 5 |
| 28563 Provide person-centred care when supporting a person with early-stage dementia | 3 | 8 |
| 28737 Demonstrate knowledge of pressure injuries and pressure care | 3 | 4 |
| 28738 Describe the key principles of palliative care and a Support Worker’s role in a palliative approach to care | 3 | 3 |
| 4. Recognise and respond to change | **Compulsory:** | | |
| 27459 Observe and respond to changes in people in a health or wellbeing setting | 3 | 4 |

1. Ministry of Health. 2014. *Final Settlement Agreement: In-between travel*. Wellington: Ministry of Health. [↑](#footnote-ref-1)
2. Ibid p.30. [↑](#footnote-ref-2)
3. health.nz/Site/Health-of-Older-People-/HBSS-Template.aspx, accessed 12 June 2015. [↑](#footnote-ref-3)
4. Deloitte, Touche Tohmatsu Limited. 2015. *Financial Review & Risk Analysis of the Home and Community Support Sector*. Commissioned by the Home and Community Health Association. [↑](#footnote-ref-4)
5. CL Stacey. 2011. *The Care Self- the Work Experiences of Home Care Aides*. Ithaca, NY: Cornell University Press. [↑](#footnote-ref-5)
6. Ibid. [↑](#footnote-ref-6)
7. Deloitte Touche Tohmatsu Limited. 2015. *Financial Review & Risk Analysis of the Home and Community Support Sector*. Commissioned by Home and Community Health Association. [↑](#footnote-ref-7)
8. Deloitte, Touche Tohmatsu Limited. 2015. *Financial Review & Risk Analysis of the Home and Community Support Sector*. Commissioned by Home and Community Health Association. [↑](#footnote-ref-8)
9. The New Zealand Certificate in Health and Wellbeing qualification framework replaced the National Certificate in Health, Disability, and Aged Support qualification framework. [↑](#footnote-ref-9)
10. Currently under consultation with the sector and expected to be introduced in 2016. [↑](#footnote-ref-10)
11. Human Rights Commission. 2012. *Caring Counts*: *Tautiaki tika*. Human Rights Commission. [↑](#footnote-ref-11)