Improving Workforce Development and Organisational Performance –

Benefits gained by embedding workplace based training in the New Zealand health and disability sector

A Report prepared for Careerforce (Community Support Services ITO Ltd)

Rose Ryan
Heathrose Research Ltd

Improving Workforce Development and Organisational Performance – Benefits gained by embedding workplace based training in the New Zealand health and disability sector

Abstract

Research on workplace learning has commonly focused on the achievement of learning outcomes by trainees. Less attention has been paid to the benefits accruing for organisations from having their employees (trainees) learning in the workplace. This qualitative research looks at the implementation of an embedded training model for care and support workers in the health and disability sector in New Zealand. Care and support work has traditionally been perceived as low skill offering minimum wages, casual employment, and little job security. Based on the experience of five workplaces chosen as case studies, the research found that embedded training not only resulted in learners achieving national qualifications, but also delivered improved quality of care, higher levels of quality assurance, and better outcomes for service users. The research found that because the training takes place in a workplace context, the costs of training are often not recognised by funders. It is clear from the case studies that embedded training promotes trainees' personal development and timely achievement of national qualifications, and also contributes significantly to organisational development.

Acknowledgements

This research was undertaken in 2009 by Dr Rose Ryan, Heathrose Research Ltd (formerly Athena Research Ltd), together with Liz Stephenson, Researcher, Workforce Development, Careerforce (Community Support Services ITO Ltd).
The authors wish to acknowledge and thank the managers and staff of the five workplaces that participated in the study, for their generosity in making the researchers welcome, and for their openness in disclosing their views and providing relevant information. Any errors of fact or interpretation are the authors' responsibility.

Table of Contents

The Embedded Training Model – Benefits gained by embedding workplace based training in the New Zealand health and disability sector

Executive Summary

Careerforce (Community Support Services Industry Training Organisation Ltd) (http://www.careerforce.org.nz/) has developed a new approach for trainees to achieve national qualifications. This approach was innovative, as training content was developed with a high level of industry involvement and an "embedded" model of training was used. Embedded training involves:

> *A workplace that has a sustainable training plan; aligns training to organisational infrastructure, policies and procedures; undertakes integrated on-site assessment of training outcomes; and aims for enhanced quality and safety.*

What this means for the workplace is that training and assessment becomes part of everyday practice. Training resources are created to align with the organisational infrastructure and policies and procedures, so that training is directly relevant to both employers and employees. Careerforce Workplace Advisors (CWAs) work with employers to support implementation of documentation and to advise on training supports and workplace assessment, in a way that works for each workplace. The embedded model of training helps to create a culture of learning within organisations by assisting workplaces to put in place systems that make learning central to their everyday practice.

This report describes the development of the embedded training model in the context of issues facing the New Zealand health and disability support services sector and contemporary approaches to skill development. In brief, changes occurring in the nature of the work undertaken by care and support workers is resulting in a re-evaluation of the worth attached to this work and of associated training requirements; and particularly addresses the higher levels (and greater complexity) of care and support provision. Careerforce's response has been to develop an embedded model of training. This approach is supported by the literature, particularly in terms of the organisational development gains that can be accrued. The embedded approach has had a high level of acceptance by employers who have put it in place and by employers and the trainees who have participated in training, in the overall context of a workforce with a low level of formal qualifications and of employers have little incentive to invest in training.

In 2009 Careerforce commissioned independent qualitative research in five case study workplaces to assess the impact of embedded training. In particular, the research was designed to outline Careerforce's model of workforce development and to provide an assessment of its impact on organisational performance for workplaces in the health and disability sector that have implemented this model. The research findings are briefly described under the key areas of examination.

The motivation for employers to contribute to workforce development through embedding training

Across all five workplaces, a strong desire to improve service delivery standards, usually linked to a stated strategic direction or mission statement, was the primary motivation for putting systematic training programmes in place. Managers identified a close connection between the training model, trainees' achievement of learning outcomes, risk management and quality assurance. Employers reported that overall the embedded training model provided better value for their workplaces than other training options.

The way in which workplaces have implemented an embedded training model

One of the advantages of the embedded model has been that each workplace has been able to customise the delivery of training to its own organisational and operational realities, and to the learning needs of its employees. The factors that influenced a workplace's choice of a particular training model included:

- Workplace size and number of employees;
- Service delivery model;
- Employee ethnicity and preferences for different learning approaches;
- Employee age and confidence with learning;
- The extent of in-house training programmes for all employees.

In addition to these factors, the five workplaces exhibited further variations relative to their operational realities, as Careerforce did not specify a particular training approach for this model. These variations included a contribution (or not) to training costs; the use of internal and external trainers, verifiers and assessors; and employees' expectations of – and commitment to – participation in the training.

The organisational supports required for successful implementation, and the costs of providing this support

A variety of supports for employees to engage in training and complete qualifications was identified. Consistent with the embedded model, these supports included training and other organisational processes, which were designed to: enhance the learning process; reward and recognise achievement; and promote the close alignment of management and administrative systems.

The research was qualitative and not designed to quantify a financial return on training investment. Follow-up research, however, could quantify the costs of embedding and calculate a likely return on investment in this particular model of training.

The short and long-term benefits of an embedded model of training

All five workplaces reported significant benefits that they considered outweighed the direct and indirect costs of embedded training.

Service delivery benefits: These benefits included improvements in quality of care and client outcomes; a greater sense of professionalism within the workforce (and greater likelihood of trainees' career progression); and efficiency gains leading to more effective use of resources. Indirect service delivery improvements also arose from enhanced opportunities for development in trainees' own communities without them having to travel away; the potential for greater co-ordination across the care continuum to support achievement of client outcomes; and national consistency in training. The research also found that having training cohorts in place built workplace relationships, and led to improved team co-operation and co-ordination and performance.

Organisational benefits: The most commonly reported benefits were reduced employee turnover and improved staff retention. Some workplaces also reported an increased capacity to attract higher quality applicants for advertised positions. Training has been associated with improvements in planning and work processes, resulting in greater efficiency and better matching of care and support workers with clients: both in terms of level of need and the maintenance of quality standards in the face of unplanned absences.

Employee benefits: Improved training outcomes, better wages and working conditions, an enhanced sense of self-esteem and greater job satisfaction were among the benefits reported by employees. Many employees also gained confidence in recognising the skills they already had. The career pathway offered by training has been important for many care and support workers, particularly those who have had less than satisfactory experiences of education in the past and for whom the embedded model opened up new possibilities for future career development.
The role of a care and support worker is included as part of the National Certificate in Community Support Services (Foundation Skills), Level 2 training, which has assisted both employees and managers to clarify their roles and to manage expectations. This training gave greater depth and meaning to the care and support worker's role, resulting in improved understanding as to why care and support is provided in this way.

Introduction

Careerforce, the Industry Training Organisation (ITO)[1] supporting the health and disability sector, has been developing national qualifications and overseeing training for care and support workers within the sector since its establishment in the 1990s. In the course of the last five years as a result of an accumulation of factors, Careerforce developed and registered new national qualifications at Levels 2 and 3 on the National Qualifications Framework (NQF). These qualifications are significant for two reasons. First, they were developed in a highly consultative and collaborative manner with the sector, incorporating content that employers identified as highly relevant to their workplace operations. Second, Careerforce has developed an "embedded" model of training as a means of delivering these qualifications. Embedded training delivery goes far beyond traditional models of on-job learning, and is based on the concept of incorporating workplace training and ongoing learning as part of core business. Although its definition is still evolving, embedded training involves:

> *A workplace that has a sustainable training plan; aligns training to organisational infrastructure, policies and procedures; undertakes integrated on-site assessment of training outcomes; and aims for enhanced quality and safety.*

This report looks into the operation of the embedded training model by way of case studies of five New Zealand health and disability workplaces. It starts with background information on the sector, together with a brief literature review that summarises factors associated with successful workplace learning models. The report then summarises the genesis of the embedded model of training before outlining the research questions and findings which suggest that the embedded model of training acts as a spur to organisational and service delivery improvements, as much as it delivers enhanced knowledge and skills to individual employees.

The Context

The New Zealand health and disability support services sector

The health and disability sector in New Zealand includes a wide range of community organisations (not-for-profit or privately owned) providing both residential and home-based services to people aged over the age of 65, as well as to people under this age whose physical or intellectual disabilities or mental health needs require specialist support. Care and support workers undertake a range of tasks that

[1] Industry Training Organisations receive funding from the Tertiary Education Commission (TEC) to design national qualifications and set and quality assure national standards; arrange for the delivery of industry training; and provide leadership within the industry on matters relating to skills and training needs.

involve care, support and assistance to people in their own homes, or in a community or provider setting, usually based on individualised care plans.

The sector has grown considerably over the past 20 years. The drivers of this growth include New Zealand's ageing population, leading to an increasing demand for services, particularly amongst Māori, Pacific and Asian population groups, and for the increasing number of people over the age of 85 (New Zealand Institute of Economic Research [NZIER], 2004). This increasing demand displays demographics and trends similar to those in other developed countries (Health Outcomes International, 2007).

In addition to straight-out increases in demand, changing client expectations mean that people increasingly wish to remain living in the community and to receive services orientated around their individual needs. While living generally healthier lives than earlier generations, older people incur higher per capita health expenditure than other age groups, reflecting their more complex health needs. Increased demand for services is resulting in correspondingly increased demand for labour, which is expected to grow between 40 and 69% by the year 2021 (NZIER, 2004). The inevitable shortages of labour supply have resulted in a situation where the need for greater attention to the education, training, development and deployment of the health and disability service workforce has been recognised as high priority (Ministry of Health/District Health Boards New Zealand [DHBNZ], 2007).

The wider context for recognising the importance of workforce development and training has seen the emergence of a range of strategies related to the health and disability sector, education and training (including industry training) and public management. *The Health of Older People Strategy* (2002) and the *New Zealand Disability Strategy* (2001) both place renewed emphasis on flexible service provision oriented around the needs of the individual; a proactive focus on maintenance of wellbeing and functioning; and the provision of integrated packages of community support. In addition, the *Health of Older People Strategy* has promoted "aging in place" for the maintenance of independence and wellbeing.

Within the education sector, the *Tertiary Education Strategy* (*TES*]) (2002) and its revision in 2007 has promoted skill development as a key to the development of a high value and high productivity economy, with significant government investment aimed at increasing the number of people with skills at Levels 1-3 (*TES* 2002) and Level 4 and upwards (*TES* 2007) on the NQF. Lastly, since 2000, all state funded agencies have been re-orientating their services away from input management to managing for outcomes.

Care and support services within the health and disability sector are funded by District Health Boards (DHBs) in the case of support for over-65-year-olds, and by the Ministry of Health and ACC in the case of support for people with intellectual and physical disabilities. Contracting arrangements between these bodies and

community and private sector providers are governed by an overall framework established by public sector central agencies.[2] Contracting arrangements with Government, however, have generally been criticised by providers in the social services – as well as in the health and disability sector – as rigid and prescriptive, and displaying little understanding of the needs of providers, many of whom have a history as charitable organisations (NGOIT, 2009). A recent small-scale survey of mental health and addictions providers (NGOIT, 2009) noted the focus of DHBs on close monitoring of inputs and scant attention paid to client outcomes, together with inconsistent funding models and purchasing arrangements. In addition, providers argued that insecurity of funding runs counter to sustainable service delivery, as providers invariably employ people on temporary contracts and see little point in investing in training.

Legislation protects health and disability service users through the Health and Disability Commissioner Act 1994 (HDC Act) and the provisions of *The Code of Health and Disability Services Consumers' Rights Regulations 1996*. *The Code* confers a number of rights on all consumers (clients) of health and disability services in New Zealand, and places corresponding obligations on providers of those services. It applies to all health and disability related services, in order to protect the rights of service users. Service standards for the sector have been the subject of considerable controversy over recent years. Under the regulatory framework of the Health and Disability Services (Safety) Act 2001, Standards New Zealand has developed Sector Standards[3] for the management of both residential care facilities and home-based care. Standards are compulsory in residential care facilities, but remain voluntary for the home and community care sector.

The health and disability care and support workforce is a component of the "non-regulated" workforce. "Non-regulated" refers to those sectors of the workforce that have no compulsory registration requirements under the Health Practitioners Competence Assurance Act 2003. The non-regulated workforce is not easily measured in relation to standard industrial and occupational classifications,[4] as many workers are employed on a casual basis. Attempts to measure the size of the workforce over recent years have included a study carried out by The University of Auckland on behalf of the Ministry of Health. Using provider based data this survey estimated the size of the workforce at between 40 and 50,000 workers (Auckland UniServices Ltd, 2004). This finding is similar to an NZIER estimate that

---

[2] Controller and Auditor-General (2008) *Procurement guidance for public entities: Good practice guide;* and New Zealand Treasury (2009) *Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown.*

[3] Service standards were first developed in 2001, but have recently been revised. New service standards came into force on 1 July 2009.

[4] Australia New Zealand Standard Industry Classification (ANSIC) 2006 includes "Residential Care Services and Other Social Assistance Services" within *Division Q: Health Care and Social Assistance*, alongside other services and service providers including "Hospitals", "Medical Services", "Child Care Services" and "Allied Health Services". Included in "Other Social Assistance Services" are adoption service, adult day care centre operation, aged care assistance service, alcoholics anonymous operation, disabilities assistance service, marriage guidance service, operation of soup kitchen (including mobile), welfare counselling service, and youth welfare service.

approximately half of the 130,000 people[5] in the sector as a whole (including hospitals), are in non-regulated professions (NZIER, 2004). A more recent analysis of aged care workers only within the care and support workforce estimated from official statistics[6] a figure of around 17,900 aged care workers in 2006, with a projected requirement of 24,500 workers in 2016 and 34,600 in 2026 (Callister, 2009). This figure of 17,900 aged care workers may reflect the fact that care and support workers in the sector have a range of job titles and may also have primary jobs in other sectors of the economy.

Successive analyses (NZIER, 2004; Auckland UniServices, 2004; Ministry of Health/DHBNZ, 2007 [Callister, 2009]) show the workforce to be overwhelmingly female, with higher than average proportions of Māori, Pacific Island and new migrant workers. The workforce also has an older age profile than other sectors in New Zealand, with around two thirds aged 40 years and over. The average age has increased over the past 10 years as the sector has struggled to attract younger workers into the industry. Employees commonly work part time (fewer than 30 hours per week), and wages are frequently reported as set at the minimum wage level or marginally above. Careerforce data shows that of current trainees, few hold a formal qualification. Other evidence identifies low levels of language, literacy and numeracy skills among employees as a significant issue for the sector (Auckland UniServices Ltd, 2004).

Many care and support workers in the health and disability sector perform tasks that support service users, whether they are living in their own homes, in the community or in a residential facility. These tasks[7] – which assist the work of regulated health professionals – commonly include personal care (including showering, bathing and toileting); support (assisting service users to do things for themselves); and less frequently, household management (such as cooking and cleaning). Increasingly, however, care and support workers are being asked to assist with prescribed rehabilitation and recovery plans, including basic clinical and nursing tasks.

While the work of care and support workers is viewed in the public mind as "low skill", there is an increasing understanding that this perception underestimates its real value. The Ministry of Health/DHBNZ (2007) has noted the way in which the non-regulated workforce contributes to restoration, recovery, rehabilitation, participation and independence across the service spectrum. Similarly, an

---

[5] The sector also includes a large number of unpaid and informal carers, most of whom are family members. The 2006 Census includes 422,901 people whose main occupation is listed as a voluntary/unpaid family or other carer, but this figure will also include a large number of people caring for pre-school and school age children.

[6] These statistics included New Zealand Census figures, the *Disability Survey of Residential Facilities 2006* and the *Household Disability Survey 2006*, together with Statistics New Zealand population projects.

[7] Although they are outside the scope of this report, the sector also includes workers performing a range of other functions including care co-ordination, cultural assessment, needs assessment and service co-ordination, in-hospital patient care assistance, education, advisory and advocacy services, diversional therapy and so on.

independent job evaluation undertaken by the Public Service Association (PSA) and four providers of residential intellectual disability services compared the work of community care and support workers to that of DHB Therapy Assistants and Corrections Officers. Comparisons across the three jobs against twelve factors relative to skills, responsibilities and job requirements demonstrated a high degree of commonality in the ratings (Top Drawer Consultants, 2009).

In summary, the changing nature of work undertaken by care and support workers is resulting in the need for training to address higher levels of complexity, together with an associated need to improve wage rates and employment conditions. These requirements are manifest in an environment in which the care and support workforce has a low level of previously acquired skills, and in which employers have little incentive to invest in training within current funding arrangements.

Careerforce's response to this situation has been to develop an embedded model of training. The next section of this report reviews some of the literature around embedding and the organisational contexts that support its successful implementation, before evaluating the processes whereby Careerforce has implemented the model.

Training models for the 21st century

Over the past twenty years there has been increasing recognition of the need for improved skill levels in all sectors of the economy. Much of this debate has centred on imperatives arising from the conditions pertaining to the traded goods sector. The literature includes well-rehearsed arguments for organisations to increase their investment in training, including increased innovation, improvements in quality assurance, making best use of new technology, and higher productivity and profitability (see for example, Ashton and Sung, 2002; Tamkin, 2005).

There is less research on the value of skill development in the service sector, in which the majority of the labour force is now employed. What research there is has shown improved levels of client satisfaction through delivery of higher standards of service, greater consistency in service standards, improved responsiveness to individual customer needs, customer loyalty and increased valuing of customers (Boxall, 2003; Liao and Chuang, 2004). Most of this research, however, has been undertaken in a commercial setting – particularly in banks and insurance – and in the hospitality industry, with little investigation into the value added by training in other service sector occupations, particularly where the work involves "care and support" functions.

At the same time, there is general agreement that improvements in skills have resulted in a wide range of positive impacts for workplaces, irrespective of the sector involved. Training results in improved organisational performance against a range of financial, operational and human resource indicators (although the difficulty in proving a causal relationship has been noted). Skill acquisition,

however, does not deliver these benefits in and by itself. A number of studies have argued that training has little value unless managers have the capacity to utilise skills effectively (Keep and Payne 2004), which requires the adoption of new organisational systems, sometimes referred to as "high-performance workplace systems". Such systems are made up of "bundles" of workplace practices to reinforce an increased focus on training and skill development. These practices include changed forms of work organisation (both systems and processes); mechanisms for improved two-way communication within the workplace; and improvements in employment relationships and the quality of management.

The interest in high performance workplace systems has resulted in renewed attention on systems for on-job learning, either complementary to, or instead of, off-job learning (particularly in the formal context of a classroom setting). On-job learning has a long history, involving both formal training and informal learning acquired through everyday work experience.

There is a growing body of literature on workplace learning that allows some generalisations to be made about those factors which are most effective in assisting learners to gain and retain knowledge. Among these factors, individual learner willingness to engage in training; learner ownership of learning goals and processes; previous success in a learning environment; and training which takes account of people's previous learning backgrounds; have been found to be important. Organisational factors are also relevant, and include a high level of management commitment to training; adequate resourcing and time for training; support for and recognition of learners; perceived relevance; and provision of opportunities to learn as part of everyday work (Vaughan, 2008; Misko, 2008).

The importance of flexible delivery models has also been identified for adult learners who may have a range of family and community commitments, and who may not have participated in education or training for some time. In particular, learning models that blend learning with practical on-job experience have been identified as effective for training existing employees.

Examples of these models include action learning approaches where learners are able to get together to share information and develop strategies for improving operational processes, or where they are able to practise skills in simulated environments (Misko, 2008). A recent report identified increased levels of success for adult learners when they were able to work within provider based programmes to personalise their own learning through flexible attendance at workplace (drop-in) learning workshops (choosing the time and the duration of their attendance); and when they were able to take learning resources away with them to study at their own convenience (Hinman and Fletcher, 2008).

At the same time, as Vaughan (2008) notes, the effectiveness of workplace learning cannot be reduced to a set of factors that are put together like a recipe. The culture of the workplace and the way in which learning is organised and supported within it

ultimately determines what learning takes place, and how effectively this learning is transferred to workplace activity.

This situation highlights the need for processes to "embed" aspects of on-job learning within other work and organisational systems. The most comprehensive application to date has been the "whole-of-organisation" approach to embedding language, literacy and numeracy skills as part of the *Skills for Life Improvement Programme* in the United Kingdom.[8] For this application organisations adopt a strategic approach in which language, literacy and numeracy are recognised as fundamental skills that underpin workers' ability to acquire vocational skills and technical knowledge, and understand how that knowledge is put into practice in a work context. This initiative has resulted in improvements across a range of indicators including learner retention and success rates, leading in turn to supervisory and management teams with improved skills in adult learning, and learners with enhanced skills and confidence at work.

Embedding training into everyday work experience is conceptually no different from embedding language, literacy and numeracy into vocational education and training. The key to embedding training is to ensure that there is a high degree of alignment of learning with day-to-day tasks, and sufficient opportunity to practise skills in a workplace environment. As much as training contributes to personal development, embedding training at the workplace also has the potential to contribute to organisational development.

Misko (2008) notes that where learning becomes integrated into workplace practices, organisations are more likely to be innovative, extend learning and reward employees. These initiatives may take the form, for example, of redesigning jobs to enable employees to experience different organisational functions; giving individuals a fuller understanding of the organisation's roles and responsibilities; and multi-skilling employees to perform a range of activities. Other benefits likely to be experienced include better staff retention, improved team performance, enhanced health and safety outcomes, and increased capacity to respond to change. Other financial benefits are likely to be experienced as a consequence of these operational improvements.

While these benefits may be claimed, there is little empirical evidence available to substantiate them. Accordingly, this research was designed to gather information on the experiences of five workplaces operating in the health and disability support sector which have been involved in embedding training for the National Certificate in Community Support Services (Foundation Skills) Level 2 (Foundation Skills) and the National Certificate in Community Support Services (Core Competencies) Level 3 (Core Competencies) in their workplaces over the last three-to-four years. The following section provides some background on the development of an embedded

[8] See http://sflip.excellencegateway.org.uk/default.aspx

training model in the sector for Level 2 and 3 qualifications, before going on to present the research and its findings.

The Careerforce Embedded Training Model

The background and context for embedding training

The story of how Careerforce has become engaged with embedded training is one with many strands. In 2001 an aged care forum was convened by the (then) Associate Minister of Health Hon. Ruth Dyson, as an advisory group on the implementation of the *Health of Older People Strategy*. As a result of concerns raised by this group, a "Quality and Safety" project was instigated by the Ministry of Health to examine issues related to training of workers providing care and support for older people and people with disabilities.[9] This project, which ran from September 2003 to December 2004, addressed issues relative to workforce development needs for workers in both residential and home-based support settings. It identified a number of high-risk issues for home-based support workers, including recruitment and retention, inadequate training, working in isolation with minimal orientation, and ongoing supervision. These issues were all exacerbated by low pay, lack of guaranteed work hours and uncertainty about future career paths. The project identified these matters as resulting from lack of mandatory standards, inadequate training of staff, and lack of flexibility in the contracting model adopted for purchase of services.

In an attempt to address training issues, in 2005 the Ministry of Health in conjunction with the sector and Careerforce (then known as the Community Support Services Industry Training Organisation[CSSITO]) developed and implemented a pilot project to implement a new National Certificate in Community Support Services qualification at Level 1 on the NQF. The project, known as the Home Based Support Services (HBSS) training initiative (the training initiative), had three key goals:

- To develop and support the implementation of training and assessment for HBSS workers to attain the national certificate;
- To test the training and assessment infrastructure and processes;
- To boost foundation level training in the HBSS sector.

The project was an ambitious one, and involved designing: recognition of currency competence (RCC) approaches; a new (embedded) workplace learning and assessment delivery approach; and all the related resources (future proofing whenever possible); together with trialling its implementation with 1,000 trainees; evaluating its success; and increasing the readiness of the wider sector to engage in

[9] A comprehensive and detailed description of the background and process for designing and implementing the HBSS training initiative can be found in the Health Outcomes International (2007) evaluation report.

training. Sector consultation was the key to development of the pilot, and included reference group meetings and a national "road show" towards the end of 2005. As a result of this sector engagement, the content of the training was closely aligned to issues that employers in the sector were facing on a daily basis. Training and assessment were closely matched to on-job work processes, and provided for on-job verification of trainee competence in practical tasks.

Implementation of the HBSS training initiative took place in three phases. Phase one involved providers with existing evidence of worker competence who wanted some of their workers to go through a RCC process, followed up by learning and assessment for any identified gaps in their competencies. Phase two (involving the majority of workplaces involved in the pilot), included health and disability providers who had already developed and implemented their own organisational policies and procedures: which was a necessary precursor to using the Careerforce provided training materials (workbooks and CDs). All phase one and two workplaces were supported by a Careerforce employed contractor who assisted them to implement the pilot. Phase three involved workplaces that were not training ready, but which had the capacity to become so within a short space of time.

At the same time as the HBSS training initiative was being piloted, the Health Workforce Advisory Committee (2006) released a strategic plan for the sector. The recommendations of this plan supported the ongoing development of national qualifications, and recommended the adoption of compulsory service standards for the sector. The committee also suggested changes to funding arrangements, away from a "fee for service" approach to one which supported "packages of care", allowing providers not only to guarantee care and support workers set hours of work but also to have greater flexibility in facilitating training and supervision. Lastly, it was recommended that additional funding be made available to providers contingent upon them having developed improved processes for orientation, training and development.

A comprehensive evaluation of the HBSS training initiative was undertaken during the course of its implementation. Not surprisingly, a number of recommendations were made that related primarily to transitional issues that occurred as a result of the speed with which implementation was occurring (such as not all the workbooks being available at the start of training). Others identified issues with longer term implications included the need for improved training of workplace verifiers; building capacity within workplaces for training processes; and developing training resources to support Māori service users and their providers.

Careerforce has adopted many of the recommendations from this evaluation. Most significantly, the Foundation Skills qualification was registered at Level 2 on the NQF in 2007, and subsequently made more widely available within the sector. An additional Level 3 National Certificate (Core Competencies) was developed to provide a career pathway for trainees who had completed the Foundation Skills qualification, and sits alongside other Level 3 and 4 qualifications that are also

delivered primarily within the workplace. New qualifications are being developed on an ongoing basis to create the full career pathway of qualifications, some with optional strands. Ten qualifications have been registered on the NQF since June 2008, and a further 14 are currently under development.[10]

Researching embedded training models in the health and disability sector

In early 2009 Careerforce commissioned independent research to assess the impact of embedded training on workplaces in the health and disability sector. In particular the research was designed to report on the embedded training model of workforce development, and to assess its impact on organisational performance for health and disability workplaces that had implemented it.

The research addressed:

- The motivation for employers to contribute to workforce development through embedding training;
- The way in which employers have implemented the embedded training model;
- The organisational supports required for successful implementation of the model and the costs of providing this support;
- The short and long-term benefits of an embedded model of training.

It is important to note that the primary focus of the research was on the outcomes for the organisation and the impact on its service delivery functions, rather than on the trainees themselves. While trainees were interviewed in the course of the research, the main emphasis was on the effect of embedding on their skills and knowledge, relative to their workplace performance.

The research was carried out in three phases. Phase one involved scoping the detailed methodology and selecting the five case study workplaces in accordance with pre-determined criteria. Phase two involved a process of engagement and getting buy-in to the research from the selected workplaces, together with data collection. Finally, phase three involved analysis and reports back to each workplace, and the development of this synthesis report. A detailed description of the methodology is set out in Appendix One.

There are two aspects of the chosen methodology that should be made quite clear. First, it was based on success case study (SCS) methodology, developed by Brinkerhoff (2002). Two key elements of SCS methodology should be noted. Like other qualitative case study methods, SCS relies less on statistical and quantitative data than on a rich understanding of the perspectives of programme participants on what they have achieved. The essence of case studies is in "story-telling", and in understanding and recording the perspectives of those who were involved. In

[10] Refer www.careerforce.org.nz for more detail.

addition, as its name implies, SCS methodology aims to uncover the internal and external contextual factors leading to successful outcomes as a result of a particular programme or intervention. While SCS methodology would generally aim to include less successful examples of implementation to provide a point of comparison, time and resources – together with limited access to willing participants – did not allow comparative data to be incorporated into this research.

Second, the newness of the embedded model within the sector in relation to the research questions being addressed restricted the choice of workplaces to those that had been early adopters of the embedded training model. This circumstance is clear from the fact that three of the five workplaces chosen as case studies had participated in the HBSS training initiative; two were involved in the Tertiary Education Commission (TEC) funded Embedded Literacy, Language and Numeracy project; and one had participated in a separate Careerforce (bi-lingual) pilot. It is therefore likely that the workplaces participating in the research are not typical of the sector as a whole, in that they were identified as having successfully implemented the embedded model. Consequently they are likely to have a more positive attitude towards training, together with systems in place for implementing the embedded model.

These caveats do not provide a reason for viewing the research findings as unrepresentative of the sector as a whole. The research aimed to focus on the conditions underpinning successful implementation and the organisational costs and benefits involved, rather than on describing general trends. In a sense, the findings challenge the widespread belief that change and quality improvements in health and disability provider organisations are difficult to achieve in a contract-orientated environment, as evidenced by the service delivery improvements and organisational benefits that can accrue from high quality management systems and practices. At the same time, the findings also present a challenge to policy makers and funders, as these findings articulate the benefits experienced by the providers and their staff including reported improvements in service quality and delivery. These results show what can be achieved with dedicated funding for workplace delivered and supported training and development, and underline the importance of funding levels that are sufficient to deliver these benefits.

This consolidated report is based on summary reports that have been provided and agreed to by each participating workplace, supplemented by selected quotes from interviews with managers and trainees at the workplaces. While these participating workplaces agreed to be named, all information in this report is presented with identifying detail removed in order to protect the confidentiality of individual workplaces and the staff within them who were interviewed.

Summary details about each of the five workplaces are set out in the table following.

Table One: Summary details of case study workplaces

	Braemore Lodge	***Disabilities Resource Centre Trust (Whakatane)***	***Laura Fergusson Trust (Wellington)***	***Lavender Blue Nursing and Home Care Agency***	***Lifewise Homecare Services Auckland***
Ownership	Privately owned	Charitable Trust (Independent)	Charitable Trust (Independent)	Privately owned	Charitable Trust (part of wider grouping involving other social services)
Nature of services examined[11]	Mental health residential services	Home based support services	Residential support – for people with physical disability	Home based support services	Home based support services
Number of employees	6 care and support workers; 11 staff in total	165 care and support workers; 186 staff in total	28 care and support workers; 34 staff in total	160 care and support workers; 176 staff in total	266 staff in total, the majority of whom are care and support workers
Employment arrangements (full time (FT)/part time (PT) mix; casual and permanent)	FT and permanent	Predominantly P/T;, predominantly permanent after a three-month trial	Mix of PT and FT staff. Predominantly permanent staff, supplemented by temporary and fixed term staff	Mix of FT, PT and casual staff. Increasing numbers of staff at higher levels of qualifications with fixed hours contracts	Predominantly permanent PT
Participation in HBSS training initiative pilot	No	Phase 2	No	Phase 1	Phase 1
Number of employees who have completed Foundation Skills Level 2 training	8	42	8	53	132
Number of employees currently undertaking Foundation Skills Level 2 training	3	86	4	49	40
Number of employees currently undertaking Core Competencies Level 3 training	5	22	4	15	19

[11] NB Some organisations provided additional services that were not reviewed as part of this research.

Findings

What is embedded training?

The embedded workplace based model makes training and assessment a part of everyday workplace practice. Careerforce has developed a series of supports to assist workplaces to embed training for national qualifications into their organisations in a sustainable way, with the overall aim of enhancing quality and safety outcomes.

Careerforce's workplace based national qualifications at Levels 2-4 on the NQF increasingly incorporate national health and disability service standards, and are aligned to the infrastructure, policies and procedures of individual health and disability workplaces. Consequently, the training and the qualifications are directly relevant to both the employer and the employees undertaking the training. The learning and assessment resources supporting the qualification are provided to each employee (trainee) once a training agreement is received by Careerforce.

As well as the learning and assessment resources, Careerforce provides services to support workplaces to train and assess their care and support workers, including:

- The services of a field-based Careerforce Workplace Advisor (CWA);
- Information about the policies and procedures required as part of the assessment of unit standards within national qualifications;
- The services of Careerforce's Training Support Team;
- Training for workplace verifiers and assessors;
- Reporting of trainee credits and completed qualifications to NZQA;
- Payment of credit fees to NZQA;
- Printed national certificates to all graduates;
- Moderation services.

Careerforce also has subsidies and rebates available through funding that it receives from the TEC, to help offset employers' costs associated with workplace based training.[12]

CWAs work with employers to ensure that their policies and procedures cover the training and assessment requirements of qualifications; are documented and accessible; and support successful learning and development outcomes. CWAs' work increasingly includes contributing to ongoing and sustainable training plans for trainees to assist them to complete their qualifications; and providing support to ensure that training is successful and that learning is transferred into practice. This support also includes assisting employers to identify naturally occurring evidence as

[12] See the Careerforce website for the most recent information on costs and rebates: http://www.careerforce.org.nz/index.cfm/1,51,0,0,html/Employers

part of the assessment requirements, and ensuring that each workplace has a trained and registered workplace assessor, or access to a roving assessor with sufficient knowledge about that workplace.

Careerforce has developed a range of resources to support employer-led training and development within organisations. These resources include training aids for trainees, including workbooks and CDs; a trainee assessment portfolio, which is effectively an assessment book for the trainee to complete for each unit standard; assessment guides for workplace assessors that establish the required assessment standards; and educational supports which provide tips and tools to promote successful workplace training.

There is no one-size-fits-all approach to embedding workplace training, and organisations across the health and disability sector adopt a variety of delivery approaches. For instance, some workplaces create in-house training sessions and trainees study workbooks in groups, while others choose to support training on a one-on-one basis through a senior staff member.

The following features, however, are common among employers who are embedding workplace training:

- Having someone within the organisation who has responsibility for supporting staff to undertake training and to map out career progressions (whether as a coach, learning champion, educator or facilitator);
- The provision of regular, supported teaching and coaching sessions;
- Stipulating training and development progression in employment contracts; and
- Linking skill and qualification acquisition to remuneration.

Careerforce's embedded workplace based training model is a critical shift away from predominantly self-paced training. Instead it seeks to create a culture of learning within the organisation by delivering training in a format which has the whole organisation and the workplace as central components. Through making training and assessment sustainable and a part of everyday workplace practice, employers are helping to ensure that their organisation has employees with the skills and motivation required to provide quality care in a safe way.

Models of Embedded Training

The ways in which embedding had occurred in the participating workplaces was varied, and in part reflected the length of time that they had already been involved in active delivery of training. Two organisations had in place well-developed systems of in-house training before the HBSS pilot; one was relatively new at providing systematic training for staff; and two others could be characterised as

having a high level of management commitment to training but without the necessary resources to carry it out.

Workplace employers were asked to describe the concept of embedded training. Across all five workplaces, two key elements emerged. The first was the concept of using resources for training that are based on the organisation's own policies and procedures – for example, the trainee's own job description might be used when discussing the role of a home-based care and support worker; or organisational procedures to be followed in the event of non-contact when a care and support visit has been scheduled. Using the organisation's own processes not only ensures that training has an immediate relevance for the trainee, but also assists in learning transfer. As one manager noted, "(*embedding) results in having the meanings and experiences that are gained through training reflected in everyday working practice*".

The second element of embedded training involved workplace practices being re-oriented around training and personal development. For example, in one workplace, when trainees are required to complete specified work-based training tasks, this requirement is also communicated to their managers, who then ensure that trainees have the opportunity to undertake those tasks. Similarly, in several workplaces, people in service coordinator roles played an important role in supporting trainees by displaying an active interest in their progress, reinforcing the importance of the training to the organisation. Where embedding is most developed, training has become part of the culture and philosophy of the workplace; and there is a clear understanding of the role that training plays in promoting positive service delivery outcomes, and monitoring and reporting on these outcomes as a matter of course and not as an afterthought. The outcome of these practices is that staff and managers have a commonly held view of organisational goals, and the way that things are done.

> *Embedding is about knowing not just that our workers know what they are doing. It's also about knowing that they are delivering service delivery plans that are the ones that have been developed by us. If we are saying that someone has to follow a service delivery plan, it is what that service delivery plan is that is the organisational flavour… so it is the on-job stuff that is what embedding is about. It's not just doing the workbooks and ticking the boxes…you can't tell how capable they are just from that. It's about how they do things and the way we transmit our organisational culture. (Workplace manager)*

Why have employers adopted the embedded model?

There is a range of reasons why employers have adopted the embedded training model over recent years. The nature of the community support sector is such that many organisations have a very strong values base to their operations, reflecting the desire to provide high quality delivery to service users and to make a positive contribution to the communities in which they operate. These values commonly extend to being a "good employer" and contributing to their employees' personal

development and sense of self-worth. Several of the workplaces included increasing staff capacity and capability as part of their strategic or business goals.

> *I've become very passionate about training…because I can see that when staff are well trained and well supported the package of care will work better…for the support worker as well as the client. If the training isn't there it all breaks down – it doesn't work for the client, but it isn't a good thing for the worker either. Training is the key to the success of the care. (Workplace manager)*

At the same time, a pragmatic approach is evident, with staff development strategies clearly linked to enhanced delivery of operational requirements in a way that is financially viable. This approach has resulted in two distinct but overlapping motivations for implementing training programmes: one based on a pragmatic response to a cost-effective training model, and the other underpinned by a commitment to improved health and wellbeing outcomes through the delivery of high quality services to service users.

> *I've been quite mercenary about it, because it was basically free. But it has opened us up to some other opportunities and openings which we've been able to take up as a result….It is a good way of changing a poorly run service – health care is only as good as the people doing the work. (Workplace manager)*

Across all five workplaces, the desire to improve service delivery standards – usually linked to a stated strategic direction or mission statement – was strongly identified as the primary motivation for putting systematic training programmes in place. A close connection was evident between training and risk management and quality assurance. While at different stages of implementation, all of the workplaces are putting in place service objectives based much more strongly on the achievement of service user outcomes, and see training as an important component in delivering these outcomes.

In all of the workplaces, training was seen as a given. In several, it had strong support from Board level downwards and was valued as part of the workplace culture. This endorsement has the effect of creating a particular momentum that reinforces the value of training, which is incorporated into all aspects of work and communicated throughout the organisation. As a result, in many cases employees had overcome their initial resistance to participating in training because of the value that was attached to it. At the same time, training was seen to contribute to the development of the organisation's culture through development of more professional and confident services.

Despite their strong commitment to training and quality service delivery, managers in each of the five workplaces considered that their ability to deliver on these aims in any systematic way had previously been constrained by contract funding models

that did not include a training costs component.[13] The subsidies and financial concessions[14] available for employers to participate in workplace-based training have contributed to the willingness of workplaces to implement an embedded training model. This was particularly the case for two workplaces, where a strong management desire to develop more systematic training had existed for some time, but where resourcing had previously constrained their ability to realise this aim. In addition, it was noted that the low income levels of care and support workers limited their ability to fund any training themselves. Thus the subsidies and rebates that have been made available to workplaces to provide training have resulted in a relatively fast uptake amongst those organisations that saw these financial measures as providing them with an opportunity to implement their plans.

> *We were quite lucky really. We had seen this as a priority for some time, but we just couldn't afford to. We'd looked at something else before, but with that and First Aid training it was going to cost $600 for every employee…and we just couldn't – didn't have any money. So it came along at a really good time for us, and meant that the costs to us and the support workers were really minimal. (Workplace manager)*

Training delivery

The embedded model represents a move away from a predominantly self-paced training model to one where delivery of training is supported in a variety of ways within the workplace. This was evident in the participating workplaces, where delivery of training differed from organisation to organisation. Even within the same workplace, flexibility in order to meet the needs of individual learners was evident. Some of the variations in the models used are set out in Table Two following.

[13] Current funding contracts are perceived by employers to be silent on how to achieve a trained workforce.

[14] See http://www.careerforce.org.nz/index.cfm/1,51,0,0,html/Employers

Table Two: Range of training delivery models in case study workplaces

Model	Extent of use in case study workplaces	Benefits
Self-directed study	In all workplaces, training includes an element of self-directed study, but only one workplace had adopted this model as the predominant form of learning.	Self-directed study was seen as being most beneficial to employees who were highly motivated and able to learn quickly. It was also seen as more flexible for trainees with many non-work-related commitments.
Self-directed with informal (one-on-one) support	All the five case study workplaces had an individual (or individuals) who oversaw training, and who was (were) available to trainees for informal support. This role of arranging or delivering training included providing support to trainees; in most instances through an "open door" policy for trainees to seek assistance when they had questions about the training. In the larger organisations, other allocated workers (usually people in service coordinator roles) played a role in answering questions from trainees. Two organisations had taken a proactive stance in designating support people to assist trainees with low literacy and numeracy skills.	One-on-one support was seen as being most useful to employees with learning difficulties and/or low literacy and numeracy skills. It was felt to be of particular value to people who are newly engaged in training, as a means of assisting them to gain confidence and overcome nervousness, and to develop study skills.
Self-directed with structured support	In two workplaces, self-directed study was supplemented by structured training sessions. One workplace had a very structured system involving workshops for 2.5 hours once a month, with a new training intake every three months. Two workplaces supplemented self-paced learning with a planned system of workshops designed around specific issues covered in the training.	Supplementing self-directed learning with structured workshops was useful for some of the more complex issues included in the workbooks e.g. culturally appropriate care for regulatory/compliance related issues. Structured workshops were also common where training activities overlapped with in-house training that was required of all employees.

Model	Extent of use in case study workplaces	Benefits
	One workplace offered the option of more structured sessions for those trainees who were more likely to learn in this environment. In each of these cases, the self-directed component included "homework" with verification and assessment tasks to be completed at the end of this training.	
Study clusters (informal)	Three workplaces had put in place – or facilitated the development of – study groups or study buddies where trainees would get together to discuss training content or work through the workbooks together. In most cases these cluster groups were convened on an informal or voluntary basis.	Cluster groups were felt to work well for people who wanted them. Some managers suggested that providing an opportunity for trainees to learn together assisted them to gain a deeper understanding of the issues and improved their retention of learning.
Structured learning sessions	While structured learning sessions were at least part of the training process for some trainees in four workplaces, in only one workplace were they the predominant form of training delivery. These sessions were held on a regular weekly basis and were paced in accordance with trainees' needs.	Structured group training sessions were felt to have an advantage in contributing to an organisationally consistent way of carrying out tasks. They were also seen as making a positive contribution to the development of a working team culture.

While all of the workplaces included an element of self-directed study (and often explicitly spelled out an obligation for employees to be prepared to undertake study in their own time), each has in place a number of formal and informal mechanisms for supporting trainee learning. One of the advantages of the embedded model is that each workplace has been able to customise the delivery of training to its own organisational and operational realities, and to the learning needs of its employees.

> *We have a set time….We put it aside and all get together. And we'll take as much time as we need to get through the books – sometimes it takes us six weeks, and sometimes it might only take a couple of weeks. It might just depend on what is in that unit standard and making sure that they understand….But sometimes things happen that you just can't avoid, and we might need to change the time or miss a week….and like, we can do that when people might be away sick or on holiday. (Workplace manager)*

> *We can ask about things that we don't understand, and they will put it into words that we can understand. And if we still don't understand, they will keep finding different ways of telling it until we do. (Employee, completing Foundation Skills Level 2)*

Trainees themselves generally expressed a preference for combining group and self-directed training. The advantages that were seen to result from combining these two learning methodologies were about keeping employees on track with their study, and being able to discuss issues in areas where they felt less confident.

> *I would try and work at home, but sometimes it was hard to open the books. It wasn't so much that I didn't have the time, more that I didn't manage my time well, didn't prioritise it. It is easier to keep motivated when I know we are going to meet and I need to be prepared. (Employee, completed Foundation Skills Level 2, currently enrolled in Core Competencies Level 3)*

> *We'll read through the books and then we start talking....It works well for me. I like it that it's not just reading – if I was doing it at home on my own it would just be the words on the page. But if someone can tell a story, and then outcomes can be discussed or whatever, it just sticks in my head heaps better. Or if I can see the pill packets or whatever, it just sticks in my head better than when it's just words on a page. (Employee, completed Foundation Skills Level 2)*

Some of the factors that were put forward to explain the reason for the adoption of a particular training model included:

1. Workplace size (and in particular the number of trainees enrolled at any one time);
2. Service delivery model (training models differed depending on whether services were residential or home-based);

3. Trainee ethnicity (trainees from Māori and Pacific backgrounds were seen as preferring group based learning);
4. Trainee age (younger trainees were perceived as having a greater degree of confidence in tackling qualifications, possibly due to more recent experience in the education system, and were better equipped for independent learning);
5. The extent to which the workplace had in place an in-house training programme for all employees (three workplaces had training plans which included activities required for the Foundation Skills Level 2 qualification).

Customising and evolving the embedded model

In addition to variation in the models of training delivery that are used, the five workplaces exhibited other variations around their operational needs. Some of these variations included:

1. The extent to which the employer contributes to the costs of training (enrolment fees and registration of the qualification);
2. The order in which workbooks were completed: three workplaces identified a set order for proceeding through them, while the other two allowed trainees' interests to determine the order of completion;
3. Whether training delivery, verification and assessment are undertaken or overseen by a dedicated workplace trainer or staff member; alternatively, whether external people are used (e.g. a pharmacist to deliver training on medications management, use of an external assessor);
4. How verification and assessment processes are carried out (for example, if assessment of trainees' competencies is integrated with work tasks), and in particular whether these functions are separated out;
5. Expectations about how quickly trainees complete the training: some workplaces allowed trainees to work at their own pace, and others had expectations about the time allowed before completion was expected.

Across all five workplaces, it was evident that the process of embedding training had been an evolutionary one. It tended to start with ensuring that staff knew how to perform tasks in line with contractual obligations, but quickly moved into identifying how work processes could be improved to deliver enhanced services

> *I was thinking about how can I shift the organisation from responding to compliance concerns, to doing things because of a pride in the work and a focus on achieving outcomes? And part of that is through training and rewards. (Workplace manager)*

Embedding generally required substantial preparatory work by each of the workplaces, including: having a staff member available to undertake administrative tasks; identifying and training assessors and verifiers; and planning for the delivery

of training. In some cases, miscalculations had been made in the early stages about the amount of organisational resource that embedding would require, leading to bottlenecks, most commonly occurring when the workplace had too few verifiers and assessors in place in relation to the number of trainees who were completing workbooks. While several workplaces had a single assessor for all aspects of the training, in one workplace all of the management team had undertaken assessor training, allowing the assessment process to be shared around and playing to each individual registered assessor's subject knowledge strengths.

> *It's a bit like the paper work. The plan is if you are going to have people going through, you have to think in advance how you are going to assess them. So as well as thinking "this is a great opportunity" we actually sat down and planned what was going to happen over three months, and six months and so on – because we actually wanted these people to go through. So we went off and did the assessor training. And that is partly about a fairly flat management structure where all of us should be able to do anything....So we all can do anything, and it makes it much fairer. (Workplace manager)*

Those workplaces that had been engaged in training for some time noted the ways in which their understanding of the training process was deepening. For several of the workplaces, while they had started out with a view of training as a way to up-skill care and support workers, they were increasingly appreciating the value of the training in changing the way that they worked as an organisation, reflecting the way in which embedding of training is a process that evolves over time.

The Costs of Embedding Training for Workplaces

Like any training model, embedded training has associated costs and benefits. It is difficult to separate out the costs of providing embedded training to workplaces, as many of the training tasks are part of ongoing, everyday, workplace practice. This section of the report outlines some of the supports that the five case study workplaces had in place to support successful implementation of embedded training, and identifies some of the associated workplace costs, before going on to outline the benefits for service delivery outcomes, the workplaces themselves, and the trainees.

The supports needed for successful implementation of embedded training

In line with the principle that embedded training involves an alignment between training and other organisational processes, the five case study workplaces had put in place a variety of mechanisms to provide incentives and motivators for employees to engage in training and to complete their qualifications. Support for trainees was considered by all the workplaces to be crucial for qualification completion in the context of a workforce that had trainees with few previous qualifications and low levels of self esteem; who were generally older (and therefore

at some distance from the formal education system); and who commonly had a range of family and community commitments that made demands on their free time. However, organisational supports were also needed by managers and administrators to ensure that training and assessment processes operated efficiently. Some of the most common support requirements are described below.

Employee commitment to training

All of the five case study workplaces reported that over time, they had felt the need to be clear with employees (particularly new employees) about expectations that they would participate in training for the Foundation Skills qualification; and that they would be expected to put time aside to work on the qualification in their own time and engage with the training. Three workplaces noted that they now raised this expectation with potential employees during the recruitment process, and that people who were reluctant to participate in training were either unlikely to be employed, or alternatively would be employed on a fixed-term or casual basis.

It is notable that in four of the workplaces, even before enrolling in the Foundation Skills qualification, new employees would have participated in a comprehensive and systematic orientation process of up to five days.[15] These orientation processes often included content drawn from the Foundation Skills qualification. In all workplaces, it was common for new employees to work with a "buddy" for some part of their orientation, in order to familiarise themselves with the nature of care and support work.

> *There is an expectation now, that someone coming on to staff does at least the Foundation Levels, and that is now being incorporated into our orientation and induction – even though that might take a little bit longer. But we use the Careerforce standards to train people in things like manual handling. (Workplace manager)*

Management expectations extend to the fact that several workplaces require employees to have been employed for a minimum of three months, and to meet other conditions (for example, being prepared to work a minimum number of hours, and undertaking personal care[16] work in addition to household duties) before they are enrolled in the Foundations Skills training. In addition, employers were of the view that the investment that they were prepared to make in training required some preparedness on the part of trainees to meet their employers' operational requirements. For example, in one workplace, at the beginning of a training intake, trainees sign an agreement to participate in all workshops; work through workbooks in their own time; and complete "homework" in expected timeframes.

---

[15] Two of the workplaces had also adapted their orientation courses as refresher courses for long-standing employees.

[16] See Glossary for definition.

Despite their expectations being made clear, most of the workplaces reported some employee resistance to participating in training. This resistance was attributed in most cases to the fact that a number of employees lacked confidence and self-esteem, together with a sense amongst some older employees that their age meant their own personal time investment would not result in an adequate return. In general this resistance was expressed in the view of older workers that they had accrued the required skills through having done the job for many years, and considered they were not in need of further development.

It was also the case for some workers – particularly for those who did not speak English as a first language – that the opportunity to participate in training was something that had not previously been offered to them.

> *I felt really good, because when I came here for the interview, I told them that my English wasn't really good. And I haven't been able to study before, because there's only me and I'm working to support my family. But they have helped me and they don't mind if I can't always (read the books) and they help me to do it, because I work really hard. It's really good and they have been really supportive to me. (Employee, completed Foundation Skills Level 2, waiting to start Core Competencies Level 3)*

Support for learning processes

Support for learning processes is one of the keys to successful implementation of the embedded model in the case study workplaces. Given the nature of the workforce, one of the most important supports offered by workplaces has been assisting people to become re-acquainted with study skills such as reading, comprehension, and recording their answers in clear language. Two workplaces had started their training process with sessions with trainees about strategies for time management, emphasising the need to put aside time to complete the training work and to identify learning strategies that worked for them as individuals. These sessions were important in acknowledging the multiple demands on these trainees arising from family and community responsibilities, and led to many creative solutions by trainees to finding the time and physical space for study outside of the immediate work environment.

Support for the learning process has also involved a realisation of the need to adapt training delivery to the needs of trainees. While this realisation was in part due to the personal attributes of those with training responsibilities, two workplaces employed people with qualifications in adult education, while another had employed a literacy and numeracy tutor to assist with training delivery.[17] One manager who had undertaken training in adult education skills reported that her

[17] Careerforce has also been participating in a TEC project designed to embed literacy and numeracy skills in industry training. Two of the workplaces in this research were also part of this pilot programme.

completion of an adult education course had resulted in a greater awareness and use of alternative learning styles, together with an increased rate of qualification completion in her organisation.

Other components of learning processes that were identified by both managers and trainees as important included:

- Open access by trainees to supervisors, service co-ordinators and training staff on a regular basis. Several trainees reported that this access had provided an avenue for them to ask questions when they felt uncertain, and had increased their confidence to "give things a go". Consequently, barriers to continuing training reduced, if and when they arose;
- Facilitation of study groups and study buddies;
- Providing work-based facilities for trainees to study in;
- Ensuring that workplace resources needed by trainees (e.g. policies and procedures manuals, health and safety materials) had been documented, and were clearly labelled and easily accessible;
- Training content that was clearly and immediately relevant to their work;
- Flexibility in the days and times that training was available, allowing trainees to manage their training, work, and family and community commitments;
- Having an opportunity to correct and re-submit assessments – which addressed trainees' fears of failure.

Recognition and rewards

An important part of the culture of embedding for each of the five workplaces has been the use of rewards, and recognition of trainees who have completed qualifications. In each of the five workplaces, wage increases or bonuses were paid when trainees completed the Foundation Skills Level 2 qualification (and on completion of the first workbook in one workplace). The possibility of a wage increase was considered to be an effective incentive in an industry in which wages are generally low.

Other ways of recognising staff achievements included noting qualification completions at staff meetings and in workplace newsletters, and presentation of framed certificates, badges and flowers. Two of the workplaces made use of larger scale graduation ceremonies, to which family members and relevant external stakeholders were invited, and which resulted in coverage in local community newspapers. The message provided to trainees (and potential trainees) by this recognition is not just symbolic, but recognises the value that is placed on higher levels of skills and knowledge within the organisation. For many employees the qualification was hard won, and represented a significant personal achievement which included recognising their existing skills; overcoming barriers such as finding time to study; language or learning difficulties; and placing personal

development on an equal footing with meeting family and community responsibilities.

> *We had a graduation ceremony and it was like....whoah! We had to think about what to wear and everything. And (family member) was so proud of me. And we had a great feed too! (Worker, qualified at Foundation Skills Level 2)*

Management and administrative systems

Support for trainees on its own, however, does not lead to successful embedding. All of the five case study workplaces had made adjustments to their management processes as part of the implementation of embedded learning. While most of the workplaces identified a general need for enhanced organisational systems and capability, three particular aspects of management systems needed to be aligned with training.

First, most of the workplaces had made changes to human resource administration, particularly in relation to the criteria used for selection and recruitment. Much greater emphasis was placed on potential employees' willingness to participate in training and development, and on ongoing management of existing employees.

Second, two organisations had identified the need to align training and administrative/IT systems, to ensure that the workplace had an up-to-date picture of training that was completed, in progress or had not been started. These systems were used to identify future training needs and to assist with scheduling (care and support for service users), and were also used in three workplaces to develop a better match between the service delivery needs of clients and the skill levels of care and support workers.

Lastly, several workplaces had put professional development and support in place for workplace trainers, assessors and trainees, e.g. the skills needed for adult education, and assisting the learning of employees with low literacy and numeracy skills (through the TEC literacy pilot). This support assisted workplaces to develop strategies for enhancing trainee learning, and was seen as contributing to higher levels of qualification completion.

The costs of embedding training

Although the research was not designed to calculate or quantify a return on training investment, identifying direct and indirect costs for workplaces that participated in embedded training was nevertheless of interest; particularly the relative costs of embedded learning as opposed to traditional off-job training. In the end these comparisons proved too difficult to make, largely due to the lack of a standard system for assessing and attributing training costs across the five workplaces.

Some of the direct and indirect costs of training (not all of which are found in every workplace that has embedded training) include:

1. Wages/salaries of an individual who undertakes training delivery and assessment (whether full time or as part of a wider role). These tasks can include preparation of training sessions, facilitation and evaluation of training sessions, marking, assessment and verification, and one-on-one coaching and support;
2. Wages for trainees who participate in training sessions, including any orientation that occurs as a precursor to training;
3. Direct training related costs[18] (e.g. qualification fees as part of signing a Careerforce training agreement for a national qualification);[19]
4. Other indirect training related costs (e.g. transport costs for employees to attend training sessions, and administrative costs associated with buddy support and study in work time);
5. Wage increases following completion of qualifications;
6. The costs of celebrating achievements (e.g. framed certificates for Level 3 and above workplace based qualifications, graduation ceremonies);
7. Replacement/backfilling for employees who are attending training.

Careerforce provides services to support workplaces to train and assess their trainees and to keep training and assessment costs as low as possible. Careerforce also has subsidies and rebates in place to help employers put in place workplace based training.[20]

There was a general sense within all the case study workplaces that the costs of training had not been recognised in their funding arrangements, notwithstanding funders' increased focus on the need for appropriately trained staff. In particular, funding was seen as being biased in favour of institutionally based training, while the case study workplaces were firmly of the view that embedded training delivered better results for them.

> *The DHB says that it wants to sign off on our training plan, but I really don't think that they really know what that means. Because we are surrounded by (other providers) who are using off-job training we are kind of getting a sense that this is the only training the DHB understands….The DHB doesn't understand the value of embedding training into the workplace. I think that the Ministry (of Health) understands this but the DHBs don't. For example, we have to be able to demonstrate the costs of our verifiers (to have this included as a training cost). But the DHB doesn't understand that link – doesn't understand the role of*

[18] Careerforce is funded through the TEC to arrange training.

[19] At the time of this research, fees of $150 for Foundation Skills and $200 for Core Competencies apply.

[20] Careerforce provides a learning resources rebate of $100 per qualification, and an assessment rebate of $100 for Core Competencies if completed within a designated timeframe. See the Careerforce website for the most recent information on costs and rebates: http://www.careerforce.org.nz/index.cfm/1,51,0,0,html/Employers.

verification in the process. Because we want to be able to see that our workers demonstrate their understanding of rights and responsibilities with their clients, not just that they can complete the workbook. But the other providers don't have that cost. (Workplace manager)

Benefits of Embedded Training

While embedding training involved a wide range of financial costs, all five workplaces reported significant benefits that they considered outweighed these costs.

Service delivery benefits

When asked about the benefits of embedded training, employers highlighted the service delivery improvements that had occurred. These improvements could be broken down into three distinct areas: improvements in client outcomes, a greater sense of professionalism amongst the workforce, and efficiency gains leading to resources being used in a more effective way.

As noted earlier, the health and disability sector is placing greater emphasis on restorative care models, designed to maintain clients' functioning and independence for as long as possible.[21] While there is no dispute that workforce skills are key to the effective operation of this service model, case study workplaces considered embedded training to be an effective means of achieving this outcome.

The reported benefits to clients as a result of increased training derive from care and support workers having a more in-depth understanding of their role, together with a greater level of awareness of client needs and what they should or shouldn't do in relation to these needs. For example, managers reported that care and support workers who had participated in the training were more likely to identify: issues that may need attending to (e.g. unattended sores); deterioration in a client's ability to maintain independence; and environmental conditions that may threaten the worker or the client (e.g. reporting falls that happened when the care and support worker was not present). Training resulted in care and support workers with a higher level of knowledge and skills, and a greater sense of professionalism which raised their expectations of their own behaviour. Two workplaces also reported positive reports from service users, who perceived distinctive differences in the level of service provided by workers who had undergone training, and those who hadn't.

I would say that it has impacted on our service delivery. There is an expectation now...and we say to them it is a profession and you have to behave in a

[21] See Glossary for definition. See also Auckland UniServices Ltd: an Economic Evaluation of the Assessment of Service Promoting Independence and Recovery in Elders (ASPIRE). Final Report Auckland University 2006, for research evidence on the value of this model of care.

professional way. Certainly, when we had our latest audit where the (service users) have been asked about quality of service...there has been quite a lot of feedback from the (service users) about people who haven't had enough training. That the people who have had the training know what it is and why they're doing it. And (others) might have lots of practical experience, but haven't taken on board some of the more theoretical things or knowledge unpinning their practice. And that is evident to the (service users)....They understand why we do things and why we have care plans and why there are protocols for doing things. (Workplace manager)

All of the participating workplaces noted that incident reporting had increased since training had been in place, providing greater safety for both clients and employees. Two workplaces noted a marked improvement in the operation of their quality assurance systems, with one workplace reporting an increased focus on "root causes" in incident investigations because of the greater amount of incident data available.

All five workplaces also noted increased professionalism amongst their employees as a result of training. For both care and support workers and their clients this represented an important shift from the job being seen primarily as an unskilled one (involving cleaning and housekeeping), to being part of the continuum of health care with a job that involves skills, training and qualifications. As well as contributing significantly to employees' self esteem, training resulted in them being treated with greater respect, and contributed to an improved sense of morale amongst both employees and their clients.

I'm just heaps more confident. Knowing that you actually know what you are doing, and that they have the confidence in you as well. It's also about confidence in the other workers. Because I know that if they have done (the training) and particularly if we've done it together and we've had a chance to discuss it.... How it was before was that we didn't know if there was a better way to do something. (Employee, completed Foundations Level 2)

As noted later in this report, professionalism has also been associated with an improvement in working conditions, particularly with respect to greater security of employment. This flow-on effect has resulted in a "virtuous circle", whereby better trained employees take the responsibilities of their job more seriously, provide improved levels of service, and gain recognition and respect as a result.

Because we want this to be seen as a professional service – we don't just come in do your housework and have a cup of tea. We're here providing professional services as part of a continuum of care and that is what we want them to be most focussed on….We want to help people to be restored and help them to achieve their goals. (Workplace manager)

Greater professionalism was also partly associated with the identification of a career pathway for care and support workers. Several employees reported looking forward to undertaking higher level qualifications in the future, and enhancing their capacity to undertake other work (under supervision) currently within district nurses' scope of practice.

Training has also been associated with the ability to achieve efficiency gains, promoting better use of limited resources. For example, workers with improved skill levels are able to perform some tasks (particularly around service co-ordination and mentoring/buddying of junior staff) that had previously required a senior manager's attention. This issue is explored in more detail in the following section.

Efficiencies have also been achieved through better matching of employees' skills to clients' needs. This improved interface between employees and clients is due to employees having a wider range of skills, and an enhanced ability to work with clients with more challenging and/or complex service needs. Several workplaces reported that having a better trained workforce had increased their capacity to take on "crunchier" cases where clients had higher or more complex needs than in the past.

While only one workplace had in place formal client satisfaction surveys that indicated demonstrably higher levels of satisfaction, in others care and support workers noted that their clients themselves had reported feeling "safer" as a result of care and support workers completing a qualification. Training also resulted in a better understanding of the rights of clients as consumers, and therefore a higher level of protection for them.

In addition to these reported benefits, two workplaces noted the potential for indirect service delivery improvements. The first of these potential improvements relates to improved community sustainability, as on-job training gives people the opportunity to work and achieve a qualification in communities that do not have formal (institutional) training establishments.

Several workplaces also noted the possibility of greater co-ordination across the continuum of care. Outcomes based models of care will require better networking with other agencies and a multi-disciplinary approach; and embedding training was felt to make a positive contribution to realising this aim. Having a nationally consistent standard for training meant that employers knew the knowledge and skill levels they could expect to see in care and support workers qualified at particular levels, which made them easier to place within the organisation. Co-ordination across providers to improve capability development more generally was also being explored by several workplaces, for example by a larger agency acting as a "training hub" to benefit smaller workplaces, particularly those providing for iwi/Māori and Pasifika based services.

Organisational benefits

In addition to improvements in service delivery outcomes, employers also identified internal organisational benefits. The most commonly reported benefit was a reduction in employee turnover and an improvement in employee retention.[22] For example, in one of the large workplaces recruitment had just taken place for the first time in four months, in comparison to previous years where it occurred on a fortnightly basis. Another workplace had reduced its recruitment cycles to three times a year. Several workplaces also noted that they were now receiving unsolicited phone calls from prospective employees, based on the recommendations of existing employees who identified the organisation as a good place in which to work.

The linkages between training and reduced turnover had been closely analysed by one workplace. In the past, the workplace had had a number of cases of abandonment of employment, and exit interviews revealed that a high proportion of those leaving were doing so because as new employees they did not feel fully prepared for the work that they were being asked to undertake: hence there was a gap between their expectations and the reality of the job. Improved orientation and training programmes had resulted in employees having a better appreciation of their roles and a better preparedness to perform the tasks required.

It was noted by several workplaces that since training has been embedded, resignations were largely for reasons unrelated to the work or the workplace – such as an employee's ill health, a decision to move location, or a lack of transport. There was also a perception in the case study workplaces that embedded training was attracting higher quality applicants for advertised positions. Several workplaces reported that a willingness to participate in training was now a basic requirement of new employees, resulting in a perception of the job as one in which career progression was possible. Three workplaces reported that they were increasingly able to attract younger employees, and attributed this circumstance in part to their capacity to offer training that was a possible entry point to a future nursing career. This attribution was supported by the comments of one young employee who had only been in the industry for a short period of time:

> *What they said about training at the interview definitely made me want the job more. Because it sounded really good, it sounded really professional. And I hadn't ever really been anywhere where they were prepared to pay for your training and give you time to do it and things like that. And the others were doing it as well – it wasn't just going to me doing it on my own. (Worker, qualified at Foundation Skills Level 2)*

[22] Due to the global recession that New Zealand was experiencing, an economic downturn during the research data gathering phase may also have contributed to these findings.

Having a Level 3 qualification that could be undertaken after the completion of Foundation Skills also opened up the possibility of other future opportunities within the industry. In several workplaces, having qualified staff in place had resulted in a re-thinking of job categories within the workplace, with qualified staff taking on higher level tasks and responsibilities.

Training has also been associated with the capacity to improve planning and work processes, resulting in efficiency gains. As noted above, staff with higher skill levels had been able to be deployed into roles with a wider range of responsibilities, which led to improved oversight of less skilled employees and the freeing up of managers to undertake strategic and relationship management tasks. Offering greater job responsibility was also seen to be important in protecting the organisation's training investment, by lessening the likelihood that employees would look for other job opportunities to utilise their new skills.

> *So we have now created this middle level position, to recognise the skills that they have and the training that they have done. So part of it was wanting to recognise the fact that people had worked hard and had passed the qualification. But in that time they also built skills that we thought we could utilise – communications skills, skills around organisational time management, that sort of stuff. Understanding how the organisation works. Initially I think they were things that they themselves never thought they could do, but the fact that they completed the training gave them the opportunity to realise perhaps that they could....Most of it is to make sure that the day-to-day running of (service delivery) is going smoothly and that things happen as they should. It takes out a lot of wasted time in crisis management. (Workplace manager)*

Training has also enabled existing employees to be offered additional clients, providing these employees with more hours of regular work. For some organisations employment formerly offered on a casual basis has been converted to permanent part-time or full-time employment, which also contributed to improved retention levels as the job became more sustainable for people on a low income. Improved work processes were particularly in evidence in one workplace, which had – over time – completely revised its business model in a way that was delivering improved client outcomes and better operational efficiencies. Employees are designated as being at a skill level determined by the level of training they have achieved, and they work in teams made up of people with a range of skill levels.

Team working has offered the organisation a range of benefits, including the flexibility to be able to maintain quality service delivery even in the face of unplanned absences. It has also led to increased overview of clients, better continuity of care, and a faster response to clients when service needs change. A team-based culture, incorporating high levels of trust within the team and between the team and management, has reduced the feeling of isolation that had been reported by some people working in home-based services, and increased the sense of solidarity within the organisation. It has also resulted in a change in the service

coordination role away from a focus on rostering and fire fighting, to an increased emphasis on quality assurance against individual service/care plans.

> *In a sense, the service co-ordination role is one that is needed because of systemic errors; for example a service user requesting a change of support worker because they are not happy with their current support worker. The service co-ordinator then has to ring several staff before they can find one who will provide the support – this requires a huge amount of administration and duplication. In order to reduce this duplication, in the first instance it is better if support workers do not need to be replaced, and secondly, if they do need to be replaced then service co-ordinators should be able to identify one support worker who has rostered availability and hand-over responsibilities with the certainty that the support worker is competent and available. With embedded training it is possible for Level 3 support workers to be responsible for monitoring clients, monitoring goals plans, monitoring Level 2 support workers. This reduces duplication and ensures that handovers are more effective and that goals are actually met. (Workplace manager)*

All of the organisational benefits that were experienced as a result of embedded training were seen as having contributed to a process of organisational development which improved service delivery; and which also enhanced the ability of the organisation to compete successfully in competitive tendering processes and to deliver packages of care in line with contractual obligations. Several workplaces suggested that they were now in a position where they had a much better understanding of client and community needs, which in relation to service funders put them at a better informational advantage than they had been in the past.

> *Looking at our policies and procedures…that was where we first made the link between these and the training. And we've developed all our own material. It's really helped us in RFPs and things, because we had such a comprehensive orientation that all our workers go through and that we can guarantee that every single one of them will do things the way they are supposed to. (Workplace manager)*

At least two providers felt that their early involvement in training and the perception that training had contributed to a better understanding of service delivery needs had put them in a position of strategic advantage with the DHB in relation to future development. For example, in some cases being able to maintain people in the community for longer had reduced pressure on hospital admissions. In addition, a substantive training function in the community sector opened up the possibility of co-operative arrangements for training staff of other providers including hospitals. Given the international shortage of nursing staff and the costs of recruitment, this availability of training was seen as having the potential to offer a range of benefits to the sector as a whole.

The other key benefit perceived by the case study workplaces was the way in which embedded training had strengthened employees' sense of collective ownership of the organisation's values and goals. Because employees are learning ways of working that are based on the organisation's own policies and procedures, there is a greater level of assurance that work is being carried out in line with contractual obligations, and also ensure that managers and employees have a common understanding of organisational goals, and the way in which duties are being carried out.

> *The Foundation Skills qualification is the best. Because we are able to put our own culture in, we are able to sit down and use this wonderful resource (the workbooks) to explain about the Health and Disability Code. And because we've all been here a while, we can tell stories and relate it to real people and real things that they instantly identify with. It's very different from sitting in a class room. And by the end of that training they are so knowledgeable about how we do things here....So we can say to them "Okay, show me where our health and safety policy is and what it says" and it makes them think about it's your organisation, your policy – and suddenly they all know the things they need. (Workplace manager)*

Also, it was reported that the implementation of training policies, procedures and records was used as evidence of meeting some of the criteria in the Home and Community Support Sector Standard.

Overall, embedded training was seen by all of the workplaces as having made a significant contribution to the development of a positive and constructive workplace culture. It has also resulted in an enhanced sense among care and support workers that they work for an organisation (rather than for individual clients); and has contributed to overcoming some of the isolation often felt by care and support workers. In addition, quality assurance processes have moved in favour of an holistic approach to problem solving which includes reviewing systems and clinical issues rather than being focused solely on individual "blame" (e.g. examining systems for transport of workers to service users' homes, and whether these systems are contributing to lateness/lack of punctuality; or identifying when service needs have changed in some way etc).

Employee benefits

The embedded model is also delivering benefits for employees in respect of improved training outcomes, increased wages and better working conditions, and enhanced levels of self-esteem and job satisfaction.

In terms of training results, the embedded model has been successful in delivering more enrolments and a greater number of completions. Careerforce data for 2008 shows that the 13% of employers engaged with the embedded model accounted for 45% of new registered training agreements for that year and 48% of qualification

completions.[23] The explanation offered by managers in the course of this research was that embedded training achieves these outcomes by providing an assurance to employees that they have accurately comprehended the learning points, and can translate this knowledge into required workplace practice. This develops employees' confidence to increase their skill levels through to qualification completion; "cements in" the knowledge transfer process; and guarantees that they are competent to carry out the tasks that are needed to be done.

Training is also delivering material benefits to employees. In all of the workplaces, wages had increased as a result of employees completing the qualification, and several workplaces noted that they had deliberately provided for a wage increase as an incentive for employees to enter into training. In addition, the changes in work processes that have resulted from embedding have delivered other benefits in terms of increased hours of work (as care and support workers are able to provide care for clients with a wider range of service needs), and improved employment security. In one workplace, this provision had been extended to the point where the most qualified employees were being offered fixed hours contracts for a minimum of four hours a day.

> *It's been really good for me, because now things are much more settled. Before I was rushing all the time because I never had regular hours and I had to have two jobs, and I didn't feel like I was looking after my family. Now I can look after them better, because I work the same hours, and I know I can be home for them after school. (Worker, qualified at Foundation Skills Level 2)*

Other benefits reported by care and support workers included an improved confidence in their ability to do their job, greater pride in their work, a sense of purpose, better job satisfaction and a sense of professionalism.

> *It has really validated things for me. You just don't realise how much you actually do and what you actually know, until you write it down. Because it's just everyday things, stuff you do all the time. And then you realise that you know more than you think you do when you have to write it down. And there are things that you don't know...like I didn't really know much about the Treaty, and it was good to learn about that (Worker, qualified at Foundation Skills Level 2, currently completing Core Competencies Level 3)*

Several care and support workers noted the interest that they had developed from gaining a greater understanding of all aspects of the work – and noted their increased attention to matters of detail about their clients' wellbeing and the environment in which they were living. As one care and support worker noted, it

[23] http://www.careerforce.org.nz/index.cfm/1,104,html

had allowed her to adopt a more holistic approach to her work, through having a better understanding of the reasons for things being done. Care and support workers also reported having a better sense of being part of an organisation, and therefore better supported in their work. Several reported feeling much safer in their work as a result of knowing what work they should do and what should be referred on, and knowing that risks were being managed by the organisation. This view was in contrast to previous concerns that they were responsible for delivering all the care and support required, regardless of whether it was in their scope of practice. And it also contrasted with the vulnerability previously felt about being "blamed" if anything went wrong.

The career pathway offered by training was a definite positive for many care and support workers. In particular, for people whose previous experiences in the education system had not been positive, the opportunity to complete a qualification based on the practical application of job-related competencies had boosted their confidence in their ability to learn new things, and enhanced their self-esteem. For support workers who had taken on the job as a "stop-gap" measure (for example, as an income supplement when children were small, or following immigration to New Zealand), the training had opened up the possibility of career development. In addition, there was some evidence of trainees undertaking support work as a pre-cursor to more formal training (e.g. nursing) in the wider health sector.

Conclusions

The embedded training model that has been put in place by Careerforce and is being used for training some of the care and support workforce in the New Zealand health and disability sector is innovative in a number of ways.

First, the content of the Level 2 and Level 3 qualifications that have been put in place has been closely aligned to legislation and regulations (in particular *The Code of Health and Disability Services Consumers' Rights*) and increasingly industry standards, e.g. the Sector Standards for home-based and residential care. This alignment means that the content of the training has a high degree of immediate relevance for employees, and provides a mechanism for employers to be assured that their workforce is delivering services in a way that is consistent with the standards they are required to meet.

Second, the model that is used for learning and assessment processes addresses many of the issues identified in the literature about the conditions associated with successful outcomes for adult learners. Apart from the immediate practical relevance of the subject matter for people's jobs, the embedded learning model allows for flexible delivery that can be customised to the operational needs of the workplace and the learning needs of employees. Employees themselves have also demonstrated a commitment to their continuing development, sometimes in the face of considerable obstacles.

Third, the five workplaces studied as part of this research had also demonstrated a significant management commitment to training of staff – another factor identified in the literature as being associated with successful outcomes. They had provided a range of supports for trainees, had invested organisational time and resource, and recognised the achievements of trainees in a way that clearly demonstrated the value they placed on gaining the qualification. More significantly, however, all five workplaces had paid attention to the culture of the workplace – not just in supporting the training, but in being open to putting in place improvements in organisational processes and procedures. These initiatives not only gave employees an opportunity to utilise their newly acquired skills, but also demonstrated employers' commitment to organisational change, as well as to employees' personal learning and development.

Fourth, the five workplaces had all experienced benefits as a result of implementing the training. Employees and managers all noted the increase in confidence and self-esteem that was evident in the workforce as a result of employees completing the qualification.

Fifth, benefits accrued both to the workplaces and to clients. Chief among these benefits was an improvement in the quality of service delivery, and enhanced quality assurance. These benefits, in turn, resulted in improved outcomes for clients, with a more preventive approach being taken to their care and support needs; a greater focus on achieving the outcomes stated in their care plans; and an enhanced ability to respond to complex care needs.

Sixth, efficiency gains were also seen through better utilisation of workers with higher levels of skill and changes in work organisation, thus delivering a quantifiable return on training investment.

Seventh, staff benefitted from the achievement of national qualifications, in terms of better wages and working conditions, an improved sense of self-esteem, and enhanced job satisfaction.

As early adopters of the embedded model, these five workplaces had access to some subsidies for workforce development. Nevertheless, implementing training involved a range of costs. Because the costs are embedded within the organisation, however, they are not easily disentangled from other general operating costs. As a result, organisations operating under tightly constrained budgets are likely to be placed in a situation where training becomes "rationed" in some way, despite the considerable benefits that can be achieved. The challenge to funders is to ensure that sufficient investment is made in improving the quality of care and support provided through the sector, by recognising that embedded training is not a low-cost alternative to off-job training, but has the potential to deliver improved health outcomes for service users, care and support workers, health and disability providers, and within the sector as a whole.

Appendix One: Methodology

As noted in the body of the report, the research was carried out using success case study methodology.[24] It proceeded in three phases: scoping, information collection and analysis, and report writing. The description of methodology outlined here focuses on the processes involved in the selection of case study workplaces, and data collection.

The selection of case study workplaces involved a process of engagement with Careerforce Workplace Advisors (CWAs), as the internal staff who have the most regular contact with workplaces employing trainees. During this process, CWAs were asked to identify two to three workplaces within their "patch" that were considered to represent successful examples of embedded training. Inevitably, it was recognised that this process was likely to involve a selection bias, in that the likelihood of success increases with experience, and "early adopters" may have a more positive approach to training. However, a prioritised short list of workplaces to be approached – with an invitation to participate in the research – was developed.

Criteria that were applied for selection on to the shortlist included a willingness to participate and be named; availability during the period of data collection; and the availability of documentation to support interview findings. In addition, selection on to the shortlist aimed to ensure that the case studies would, as much as possible within the small scale of the research, reflect a range of services provided, workplace size and geographical spread.

Workplaces were then informally approached by phone to ascertain their willingness to be involved. Following a positive response, a formal letter of invitation was sent by the CEO of Careerforce. In the event, all of the workplaces ranked as the top five on the shortlist agreed to participate in the research.
In addition to the selection process, the scoping phase involved the development of standard documentation to be used in the research, including identification of information to be collected at each workplace, participant consent forms, a letter to workplaces inviting their participation, and information for workplaces on the purpose of the research. The information to workplaces on the purpose of the research and general research questions are included as Appendix Two.

Workplaces were engaged through an initial meeting with the CEO and/or senior manager. From this meeting were set out: the time and resource requirements that

[24]Success Case Study (SCS) methodology, was developed by Brinkerhoff (2002). This methodology relies less on statistical and quantitative data than on a rich understanding of the perspectives of the programme participants and what they have achieved. The essence of case studies is in "story-telling", and in understanding the perspectives of those who were involved. In addition, as its name implies, the SCS method aims to uncover the internal and external contextual factors leading to successful outcomes as a result of a particular programme or intervention.

would be involved for each workplace; the manner in which communications with staff about the research would be handled; the identification of a key contact and any sensitivities that needed to be taken account of; and the written material available to support interview data. A protocol for engagement was agreed with each workplace.

Data collection took place in visits taking between one or two days. In each case, the primary interview involved the most senior manager for each workplace, together with the person(s) responsible for training arrangements. In addition interviews were held with – as appropriate – people involved with training and quality assurance, and employees who had completed the Level 2 (Foundation Skills) qualification. Unstructured interviews were conducted around the following key research questions:

1. What are the key features of the Careerforce embedded model of training?
2. What is needed for employers to adopt an embedded model of training?
3. What organisational supports are needed for an embedded model of training to be successful?
4. What organisational obstacles have been experienced in adopting an embedded model of training?
5. What have been the costs and benefits to the organisation of introducing an embedded model of training?
6. What has been the experience of employees who have participated in an embedded model of training?

Appendix Two: Information Provided to Workplaces on the Research and Research Questions

Background to the Research

Careerforce has been pioneering new ways of linking processes of workforce development with business development. Amongst other things, this has involved developing an "embedded" model of skills development. This involves employer support for workplace based training for care and support workers in aged care and disability services and for hospital based health care assistants.

Experience with the model so far has suggested that it has a number of benefits. These include access to training for staff with few previous qualifications, and a higher rate of qualification completions.

Anecdotal evidence suggests that benefits are also being delivered to employers. In particular, employers report training that is more relevant to their workplace requirements, an improved workplace culture, higher retention rates through lower turnover, improvements in quality assurance processes and cost savings.

The purpose of the research is to attempt to document and assess the value that is being delivered to organisations in the aged care and disability support sector, offering both residential and home-based services. While it is a small-scale research project involving five case study workplaces, it will provide valuable information on return on investment in workplace based training, together with some employer perceptions of the success of workplace based training, in comparison to other models. It is also intended that the research will identify future research questions to be answered.

Key Research Questions

Key research questions include the following:

1. What are the key features of the Careerforce embedded model of training?
2. What is needed for employers to adopt an embedded model of training?
3. What organisational supports are needed for an embedded model of training to be successful?
4. What organisational obstacles have been experienced in adopting an embedded model of training?
5. What have been the costs and benefits to the organisation of introducing an embedded model of training?
6. What has been the experience of employees who have participated in an embedded model of training?

Bibliography

Ashton, D. and Sung, J. (2005). *Supporting Workplace Learning for High Performance Working.* Geneva: International Labour Organisation.

Auckland UniServices Ltd (2004). *Disability Support Services in New Zealand – Part 1: Service Provider Survey.* Auckland: Auckland University.

Boxall, P. (2003). HR strategy and competitive advantage in the service sector. *Human Resource Management Journal,* 13(3): 5-20.

Brinkerhoff (2003). *The Success Case Method: Find out Quickly What's Working and What's Not*. San Francisco: Berrett-Koehler.

Callister, P. (2009). *The Future Demand for Paid Caregivers in a Rapidly Ageing Society.* Wellington: Department of Labour.

Health Outcomes International (2007). *Evaluation of the Home Based Support Service (HBSS) Training Initiative*. South Australia: Health Outcomes International.

Health Workforce Advisory Committee (2006). *Care and Support in the Community Setting.*

Hinman, J. and Fletcher, M. (2008). *Developing Models of Flexible Delivery of Skills for Life Provision.* Reading: CfBT Education Trust.

Keep,E; and Payne, J. 2004. '"I can't believe it's not skill": the changing meaning of skill in the UK context and some implications', in G. Hayward and S. James (eds.), *Balancing the Skills Equation – Key issues and Challenges for Policy and Practice*. Bristol: Policy Press, 53-76.

Liao, Hui; Chuang, Aichia (2004). A multilevel investigation of factors influencing employee service performance and customer outcomes. *Academy of Management Journal*, 47(1): 41-58.

Ministry of Health and DHBNZ (2007). *Future Workforce: A Career Framework for the Health Workforce in New Zealand*. Wellington: Ministry of Health and District Health Boards New Zealand).

Misko, J. (2008). *Combining Formal, Non-formal and Informal Learning for Workforce Skill Development.* Australia: NCVER and Australian Industry Group.

NgOIT (2009). *2008 NGO-DHB Contracting Environment.* Wellington: Platform Charitable Trust.

NZIER (2004). *Ageing New Zealand and Health and Disability Services: Demand Projections and Workforce Implications 2001-2021: A Discussion Document.* Wellington: Ministry of Health.

Tamkin, P. (2005). *Measuring the Contribution of Skills to Business Performance: A Summary for employers.* Brighton: Institute for Employment Studies.

Top Drawer Consultants (2008). *Community Support Workers – A Job Evaluation Exercise.*

Vaughan K. (2008). *Workplace Learning: A Literature Review* – Report prepared for Competenz, NZ Council for Educational Research.

Glossary

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

Personal care
Personal care is care that is outlined in a person's service delivery plan and may include: skin care, personal hygiene, dressing and undressing, toileting, continence care, positioning an individual in bed, and assistance with eating and drinking.

Integrated assessment
Where a number of unit standards are assessed at one time removing duplication and making the workplace qualification assessment process more efficient. When assessment is not integrated, unit standards are assessed on an individual basis regardless of the fact that some crossover of unit standard content may exist.