Who will care?

The recruitment and retention of community care (aged and disability) workers

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Abbreviations

ABS
Australian Bureau of Statistics

BSL
Brotherhood of St Laurence

CACP
A Community Aged Care package is a ‘tailored package of care’, coordinated by a case manager or broker, that is designed to support an older person who would otherwise require entry, or be at risk of entry, to residential care to remain living at home. CACPs are funded by the Commonwealth Government.

DHS
Department of Human Services

DOI
Department of Infrastructure

HACC Program
Home and Community Care Program. Services provided under this program are designed to assist the frail aged and people with disabilities to remain living at home.

IRSED
Index of Relative Socio-Economic Disadvantage

MAV
Municipal Association of Victoria

VAHEC
Victorian Association of Health and Extended Care

Glossary

Community care

Generic term used to describe the care or assistance provided to frail older people or people with disabilities who are living at home. These services may be provided with HACC Program funding, may be funded from other sources or may be privately purchased by the individual or family.

Community care workers

Generic term used in this report to describe workers who provide home care, personal care or respite care services. The HACC Program, however, defines community care workers as those involved in the provision of home care, personal care, respite care, planned activity groups, delivered meals and home maintenance.

Delivered meals

Subsidised meals delivered to people assessed as being at nutritional risk, at the client's home or at other locations where appropriate.

Home-based care

The care or assistance provided to frail older people or people with disabilities who are living at home. Also sometimes called community care (see above).

Home care

Housekeeping tasks such as vacuuming, cleaning, dishwashing, making beds, laundry, ironing, shopping, escorting, bill paying and meal preparation, plus some cyclical tasks such as spring cleaning.

Home maintenance (also called property maintenance)

Assistance with maintenance and repair of the client's home, garden or yard to keep their home in a safe and habitable condition. Examples are minor repairs to the dwelling, changing light bulbs, replacing tap washers, carpentry and painting, unblocking drains, replacing guttering, lawn mowing and the removal of rubbish. Home modification refers to assistance with modifications or renovations to the client's home to help them cope with a disabling condition. Examples are the installation of grab rails, ramps, shower rails, special taps and emergency alarms.

Long-term care

A term used in the United States of America to describe the ongoing care that is provided for frail older people or people with disabilities. It encompasses care provided in both residential facilities and to people who are living at home.

Personal care

Assistance with daily living tasks which a person would normally do for himself or herself but because of illness, disability or frailty they are unable to perform unaided. Examples of personal care are bathing, showering, dressing, grooming, toileting, assistance with getting in and out of bed, escorting, and assistance with mobility and eating (including cooking and preparation of food).

Planned activity groups

Groups which focus on supporting an individual's ability to live at home and in the community, by providing a planned program of activities intended to maintain daily living skills. These activities also provide social interaction as well as respite and support for carers. The group may meet in a centre or at a local venue, or go on outings.

Residential care

Care provided in a residential setting such as a nursing home or hostel (high or low care home) or in a residential facility for people with disabilities. Nursing home beds are also referred to as high level care beds. Hostel beds are also referred to as low level care beds.

Respite care (in-home & community)

Services designed to support the caring relationship by providing carers of frail older people and people of any age with a disability, with a break from their caring responsibilities. Respite may be provided in a care recipient's home or in the community. It may be provided in the form of planned regular respite, emergency respite, crisis respite, and occasional respite. It may involve the substitute carer accompanying both the usual carer and the care recipient on an outing or holiday

Respite care (overnight)

Overnight respite is provided in the client's home in a 10-hour block. The worker sleeps overnight, and is available to respond to a call for assistance

Note: several of the above descriptions come from the Department of Human Services web site, <http://www.dhs.vic.gov.au/rrhacs/fundplan/downloads/rrhacs_plan_2002.pdf, pp.86-87>.

Summary

Community care is provided to frail older people or people with a disability who wish to remain at home, and includes services such as home care, personal care and respite care. Due to the ageing population, the number of people who will require community care support is expected to significantly increase, yet many organisations which provide this type of assistance are finding it increasingly difficult to recruit and retain suitable workers. The Victorian Association of Health and Extended Care (VAHEC) and the Brotherhood of St Laurence (BSL) were funded by the Home and Community Care Program (HACC), Department of Human Services (DHS), to investigate strategies implemented by community care organisations to improve both the recruitment and retention of community care workers. The main objective of this study was to document and publicise key strategies so that they may be implemented more widely across the sector.

Questionnaires were sent to all community care organisations throughout Victoria that were identified as providing HACC and HACC-like services. From the 159 organisations that returned completed questionnaires, 11 organisations were selected to be interviewed, having been identified as implementing innovative or diverse methods to improve the recruitment and retention of their staff. The questionnaire asked organisations about the demographics of their workforce and work practices, and the interviews expanded on this information.

Included in the questionnaire data was information about approximately 8,600 workers, of whom 90% were female. More than 50% of workers were aged 45 years and over. The majority of workers were employed on a part-time or casual basis.

Four central topics were identified: recruitment, retention, qualifications and training, and staff support. In terms of recruitment, almost half of home care service providers (43%) had difficulty recruiting suitable staff within the last 12 months, whilst over half of personal and respite care service providers experienced similar problems. Organisations had significantly less difficulty recruiting for other community care services such as planned activity groups, delivered meals and home maintenance, with only a small minority experiencing these problems. Of the nine DHS regions, Hume appeared to experience the least recruitment difficulty, whilst organisations within the inner metro and small shire regions appeared to experience greater difficulty with recruitment. For-profit organisations appeared to experience more difficulty recruiting than local government and not-for-profit organisations, and local government organisations located in socio-economically advantaged areas also appeared to have more difficulty recruiting. Unfortunately, reliable statistical significance tests were not possible due to the sometimes small number of organisations within each category.

Staff turnover was also an issue for many organisations, with just under half indicating they were concerned with their organisation's staff turnover rate. Those particularly concerned were organisations within the Gippsland region, those in regional cities, and those in areas with less socio-economic disadvantage. Almost one-third of organisations estimated their turnover rate as 10-20% in the past 12 months, whilst approximately half estimated it to be below 10%. The majority of organisations supported their staff with some form of training, with almost all organisations providing in-service training. Upskilling workforce programs were also popular; and approximately half the organisations used state government-funded training places and/or new apprenticeships/traineeships. Once again, reliable tests of statistical significance were not possible.

The frequency of face-to-face support for workers in the form of supervision or staff meetings was highly variable, with approximately one-third of organisations meeting at least monthly, and 16% meeting only on a quarterly or half-yearly basis. Approximately half the organisations recognised their staff's contribution with non-monetary rewards such as certificates and lunches or dinners.

Whilst the opinions of workers regarding the general conditions and recognition of community care jobs were not directly investigated in this study, previous research as well as some anecdotal data collected in this study suggested that many factors such as pay, respect and image also have a major impact on recruitment and retention. Employers seeking to improve recruitment and retention outcomes should therefore consider the following aspects of their human resources management:

- job structure (full-time, part-time and casual work)
- recruitment processes
- staff composition (e.g. age and gender of people employed)
- rewards and recognition of staff
- opportunities for career development
- staff support
- staff involvement in rosters and clients' care plans
- staff training.

The broad aim of this project was achieved, as innovations and strategies implemented by various organisations have been identified as worthy of consideration by the industry. This study provided information about the community care workforce in Victoria, as well as quantifying the experiences of service providers in recruitment and retention. Further research is needed, however, particularly in terms of how recruitment and retention interventions should be measured, how the pool of workers could be expanded to include males and the younger population, and how the image and status of the industry could be improved. Service providers need to look at the way they structure their recruitment and retention processes as well as at ways to improve the image of the industry. Without these changes, the community care workforce will not be able to meet the growing demands that are predicted for the future.

Introduction

Background

The range and availability of services to assist frail older people and people with disabilities to remain living at home have increased markedly over the past two decades. The providers of these services have, however, found it increasingly difficult to attract and retain direct care staff.

The Victorian Association of Health and Extended Care (VAHEC) recognised this trend and in 1999 established a taskforce to investigate these issues. A forum convened in 2000 confirmed the sector's concern over staffing issues and resulted in the development of a workforce strategy. This research project, developed jointly by VAHEC and the Brotherhood of St Laurence (BSL), was designed to add to other workforce initiatives being undertaken by VAHEC.

Funding for the project was received from the Victorian Department of Human Services Home and Community Care (HACC) Program, as it complemented work being undertaken within the HACC Workforce Development Strategy Project. The project was to have three phases:

- a questionnaire to obtain information on recruitment and retention strategies being implemented by organisations to address their staffing issues
- interviews with selected organisations to further explore the recruitment and retention strategies
- a forum to share findings with community care providers.

Aims

Specifically, the research aimed to:

- investigate the extent and type of work being undertaken by aged and community care providers to improve the recruitment and retention of direct care staff
- document key strategies in some detail and, where available, analyse existing service data to assess their effectiveness
- publicise initiatives being undertaken so that they may be implemented more widely across the sector.

Methodology

Definition

For the purposes of this research, direct care workers or community care workers were identified as those involved in the provision of home care, personal care and respite care services. It is acknowledged that these terms can also be used for planned activity group workers, delivered meals staff and home maintenance staff. In this report, these other workers will be clearly identified, and any unqualified use of the term 'direct care worker' or 'community care worker' should be interpreted as above. Note, however, that this is different from the HACC program definition (see Glossary).

Project management

The project was jointly managed by VAHEC and the BSL, with the research undertaken by BSL staff. A project advisory committee was formed to provide advice and support on the overall conduct of the project. In particular, the committee provided assistance with methodology, interpretation of data and advice on the final report. Committee members included representatives from DHS, Municipal Association of Victoria (MAV), local councils, Carers Victoria, Council of the Ageing, Australian Services Union-MEU/Private Sector

Victorian Branch, Health Services Union of Australia, VAHEC, VAHEC members and the BSL.

Project design

The original project was designed to consist of a questionnaire to provide both qualitative and quantitative data, and interviews with a small number of selected organisations.

A literature review was added to the project design to assist in the development of the questionnaire. It was also undertaken to identify recent research about the recruitment and retention of community care workers, including the identification of factors affecting the supply of workers and interventions implemented to address staffing difficulties.

The primary function of the questionnaire was to provide information about the strategies organisations had implemented to improve recruitment and retention outcomes, and to identify organisations to be approached to participate in interviews. The questionnaire was to be sent to providers of home care, personal care and respite care services. The questionnaire was, however, designed to ensure it also allowed the researchers to quantify the extent of difficulties being experienced by the community care industry, and to provide information about the characteristics, structure and organisation of the workforce.

At the request of DHS, the questionnaire was expanded to enable it to be sent to organisations that provided other community care services such as planned activity groups, delivered meals and/or a home maintenance service. Specific questions for providers of these other services were included as a separate section of the questionnaire.

Follow-up interviews were conducted with a small number of organisations that provided extensive information on the questionnaire about how their community care work was structured and how they recruited and supported workers. A range of organisations (of different types, locations and sizes) were selected on the basis of their use of innovative or comprehensive strategies to recruitment and/or retention. Three of these interviews are presented as case studies in this report.

This report, together with the forum held with the sector, disseminates the information gained by this research into this important community care workforce issue.

Sample

With assistance from DHS, MAV and VAHEC, a mailing list was developed that identified 393 organisations from across Victoria as being involved in the provision of some form of community care. This included community care organisations throughout Victoria that provided HACC and HACC-like services. The sample was developed from DHS's HACC Program list, VAHEC's community care service providers' list, and MAV's council contacts, in order to ensure a thorough geographical distribution and include culturally and linguistically diverse organisations. Questionnaires were sent to each of these organisations with the understanding that not all would necessarily employ the type of community care workers targeted by this research (e.g. an organisation providing delivered meals may use volunteers for meal delivery, or an organisation may be funded for brokerage services only).

Follow-up telephone calls were made in order to increase the response rate. These were restricted to known providers of home care, personal care and respite care services. This decision was based on information from the questionnaires received by the closing date, when it became apparent that few organisations which had responded by that date and provided planned activity groups, delivered meals or home maintenance were experiencing difficulties with the recruitment and retention of staff. This decision may have resulted in an underestimation of the

extent of the problems being experienced by organisations that only provided planned activity groups, delivered meals or home maintenance.

Eleven organisations across a range of types, locations and sizes were selected for interview from the information they provided on their questionnaires.

Analysis

Once participants had returned the completed questionnaire to the researchers, the data was coded and SPSS was used to perform frequency calculations and Pearson Chi Square analyses. Coded data was also used to construct tables and graphs data presentation. Qualitative data extracted from the questionnaire was analysed manually.

Literature review

> One of the more important policy developments in Australia over the past decade has been the shift in the balance of care away from residential care and towards home-based care. While older Australians continue to rely on family and friends for the vast bulk of the assistance they need, the increased availability of formal community-based and domiciliary services has resulted in greater opportunities for frail older people to remain living in the community. (AIHW 1999, sheet 17)

Home-based care, commonly known as community care, assists a large number of frail older people and people with disabilities to fulfil their desire to remain living at home and provides the potential for cost containment by constraining the provision of expensive residential care (Gibson & Mathur 1999). Unfortunately, many organisations that provide assistance to people living at home (such as those who provide home care, personal care and respite care services), have stated that they are find it increasingly difficult to attract and retain suitable workers. This experience is not unique to Australia, and is shared by many countries including the United States of America (Dawson & Surpin 2001, Straker & Atchley 1999), European Union members and Japan (Christopherson 1997, cited in Stone & Wiener 2001). The provision of adequate care and support for the ageing population in Australia and throughout many parts of the world is set to increasingly occupy the minds of policy makers, service providers and the broader community.

Who needs care?

A significant proportion of the Australian population either has a disability or is providing assistance to someone with a disability. The most recent *Survey of Disability, Ageing and Carers* (ABS 1998b) estimated that more than 1.9 million people needed assistance to move about, shower and/or dress, prepare meals, conduct housework, perform light property maintenance or paperwork, or communicate (ABS 1998b). The majority—1.4 million—received informal assistance from relatives and friends (ABS 1998b). Many of these informal care-givers, however, need assistance themselves when it comes to helping their relatives or friends. The role of a carer, which may continue over many years, may be emotionally and physically demanding, and carers may experience the sensation of being trapped in the role and feel they lack control over their daily lives, which impacts on their health, prosperity and well-being (Noelker 2001). In 1998, it was estimated that more than 900,000 people who needed assistance to perform one or more everyday tasks received support from formal care providers (ABS 1998b). The majority of this formal care is provided through services funded by Commonwealth, state and territory governments, particularly the Home and Community Care (HACC) Program, Community Aged Care Packages (CACP) and the Disability Services Program.

With the ageing of the population, however, the number of people requiring assistance is expected to grow markedly over the coming decades, because as people age, their need for assistance increases, regardless of whether they have a disability (ABS 1998b). It has been estimated that approximately 50% of people aged 75 and over require assistance with at least one everyday activity (such as personal care, housework, meals or transport), rising to more than 90% of people aged 85 and over (ABS 1998b). In Victoria, it is estimated that the number of people aged 75 and over will rise from about 280,000 in 2001 to approximately 425,000 by 2021 (DOI 2002). Many of these people will receive assistance from informal care-givers, but the need for formal care can also be expected to significantly increase.

Who provides care?

According to Dawson and Surpin (2001), the US direct care industry was structured on the presumption that an endless supply of low-income women would be willing to provide care and companionship for little in return. Traditionally, direct care workers in the US have been

economically disadvantaged women with low levels of education. These workers, however, are not as readily available as they once were (Dawson & Surpin 2001). Interestingly, the development of the Australian community care system has some parallels to the US experience, having also relied on care being provided by middle-aged women who were willing to work for relatively low rates of pay and who were employed on a part-time or casual basis. In a study of South Australian HACC providers, Barnett and Associates and Sloan (1999) found that the average age of the workforce was 47.5 years (with the majority aged between 40 and 55), and that 83.4% were women. It should be noted that this study involved administrative, management and professional staff as well as direct care workers and volunteers.

The Victorian Association of Health and Extended Care (VAHEC) recently funded research to gain a better understanding of current wages and conditions within the community care sector, and to uncover issues affecting the attraction and retention of community care workers (VAHEC 2002). It was a small study of 23 not-for-profit and private-for-profit organisations that provided home care, personal care and/or respite care services, and did not include local councils which provide similar services, but as it is the only recent Victorian material and is one of the few studies to include an employee perspective, its findings will be noted. The study confirmed the perception that direct care workers were predominantly female, middle-aged and employed on a part-time or casual basis. Employer respondents (covering a total of 5,825 employees) indicated that casual employees made up 63% of the workforce, 35% of workers were employed on a part-time basis, and only 2% were employed as full-time workers.

Supply of community care workers

The US, which has a similar age profile to Australia, is leading the way in drawing attention to the difficulty of ensuring the adequacy of the supply and quality of long-term care workers. In recent years, a number of reports have been published describing the extent of the problem in the US, as well as possible responses (Dawson & Surpin 2001; Dawson, Rico & Trocchio 2001; Stone & Weiner 2001; Straker & Atchley 1999). Of particular concern are the issues of the recruitment and retention of long-term care workers:

> Those responsible for recruiting, training, or supervising direct care workers in long-term care organisations hold one of the most challenging jobs in health care today. That is because direct care workers…are increasingly hard to find. Once found, they are increasingly hard to keep. Staff vacancies make a supervisor's job especially difficult because 'working short' increases the stress on all those who do remain on the job. (Dawson, Rico & Trocchio 2001)

Reported turnover rates for staff employed in US home care programs vary greatly, ranging from relatively low rates of 10% (Hoechst Marion Roussel 1996 cited in Straker & Atchley 1999) to reported rates of 50-75% annually (Communication Concepts 1997 cited in Straker & Atchley 1999).

The recent Victorian study by VAHEC (2002) found that approximately one-third of organisations reported an annual staff turnover of 21-30%. It should be noted, however, that a study in the US found only very moderate correlation between organisations' estimated turnover and their actual computed turnover, indicating that many agencies dramatically underestimated the extent of the problem (Straker & Atchley 1999). The same study found that 47% of the agencies surveyed rated recruitment as a serious problem. Whilst comparable information has not been found for Victorian community care providers, discussions at industry forums and meetings have indicated that organisations are becoming increasingly concerned about the recruitment and retention of staff.

Staff turnover has consequences, not the least being the cost of recruiting new workers to replace staff who leave. Providers spend significant amounts of money recruiting and training staff, only to find that many of them stay for relatively short periods of time (Dawson & Surpin

2001). This turnover increases management and lost productivity expenses, creates separation costs for exit interviews, separation pay, and administration, and leaves employers with high temporary replacement costs (Stone & Wiener 2001). Unfortunately, organisations rarely collect adequate information to allow them to compute the real cost of turnover (Straker & Atchley 1999), making it difficult to do a cost-benefit analysis of implementing strategies to decrease turnover.

Workers affected by the high staff turnover of their colleagues may experience greater frustration and stress with their increased number of clients, feeling they are unable to devote adequate time to each individual client (Dawson & Surpin 2001, Stone & Wiener 2001). It has been speculated that staff shortages may also create higher risks of injury, although there does not appear to be any research documenting this direct relationship (Stone & Wiener 2001). High turnover among care staff also may impact on the quality of care that consumers receive (Dawson & Surpin 2001). Stone and Wiener (2001, p. 14) also raise this issue, commenting that the 'reduced availability and frequent churning of such personnel may ultimately affect clients' physical and mental functioning'.

Factors affecting the supply of workers

Baldock and Mulligan (1996), in a study of home care workers in Western Australia, identified several issues that negatively affect direct care workers and may impact on the recruitment and retention of people in the community care industry. They were concerned that while most direct care workers were multi-skilled people working flexible hours, they often received no penalty rates and were frequently employed on a casual or contract basis (receiving no annual leave, sick leave, or other benefits offered to permanent staff). Many were not guaranteed minimum hours of work, were not paid according to their skills, and had limited access to paid training. Research in the United Kingdom provides support for the idea that the quality of the employment conditions affects turnover, with one study suggesting that low rates of pay contributed to the frequent move of workers between employers (Joseph Rowntree Foundation 1998).

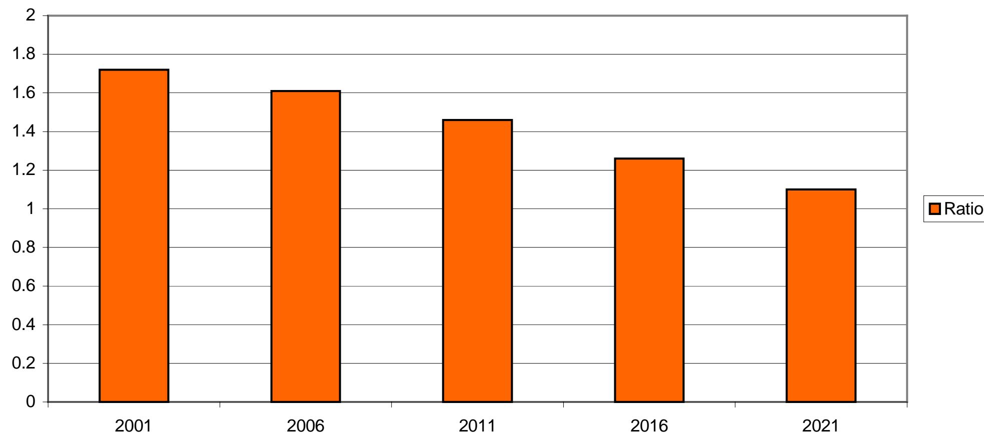
The Victorian research by VAHEC (2002) also provides support for the idea that conditions of work affect the supply of workers. In this study, care workers reported that pay increases for experience, regularity of work, and an increased base rate of pay were the most important improvements that could be made to encourage them to continue working in the industry. Additional issues that employees rated as needing greatest improvement were 'being paid for travel', 'receiving information about things that affect them' and receiving 'feedback on performance'. Work-related travel can take up a significant proportion of care workers' time, yet only about two-thirds of employers in VAHEC's study reimbursed staff for use of their own vehicle to travel between clients at a per kilometre rate (it is unclear whether staff were paid for their travel time between clients). Performance appraisal programs, an important feedback mechanism, were also in place in only two-thirds of organisations.

Both the limited respect shown for the knowledge of direct care workers and the image of the industry may influence the limited supply of workers. Even though workers spend a significant amount of time with clients, enabling them to gain valuable knowledge, they are often not considered to be a member of their clients' health-care teams (Dawson & Surpin 2001) and may not be included in care planning. The way in which society perceives this occupation is also thought to affect the supply and quality of direct care staff, a perception not helped by media reports that feature poor quality care by providers (Stone & Wiener 2001).

The condition of the labour market further affects the supply of community care workers (Dawson & Surpin 2001; Stone & Wiener 2001), particularly impacting on the size of the pool of workers from which the industry can draw their workforce and on the availability of other employment opportunities.

Dawson and Surpin (2001) considered the issue of the supply of workers by looking at what they termed the 'elderly support ratio'. Aware that the majority of formal caregivers were women, they were able to use population projections to calculate the ratio of women aged 25-54 to the total population aged 65 years and over. In 2000, the ratio was 1.74:1, but it is estimated to fall to 1.15:1 by 2020. They concluded that this long-term structural problem may increase the mismatch between the supply and demand for direct care workers. Using DOI population projections (2002) this ratio can be calculated for Victoria (see Figure 1).

Figure 1 Elderly support ratio, Victoria 2001-2021
(females aged 25-54 per individual aged 65 and over)



Mirroring the situation in the US, there is a steady fall in the predicted ratio for Victoria over the next two decades, from 1.72:1 in 2001 to 1.1:1 by 2021. Unless community care becomes a more attractive employment option, either for women who provide the majority of care at present or for men, organisations can expect to have increasing difficulty providing formal care for those who require it.

On a more positive note, the relationships that workers developed with clients and the satisfaction of feeling they make a difference to people's lives appears to encourage workers to remain in the industry. Some workers are drawn to the community care sector, at least in part, by their desire to help, and many workers who remain do so because of the satisfaction they gain from their relationships with residents (Dawson, Rico & Trocchio 2001). The research by VAHEC (2002) provides support for this contention, with direct care worker respondents stating that 'personal satisfaction and achievement' and 'to make a difference to clients and their families' were the key issues that attracted them to the care industry. A similar conclusion was made in the UK study by the Joseph Rowntree Foundation (1998), which, however, added that if workers sensed that an employer was ignorant of worker commitment and input (to both the organisation and to clients) a higher rate of staff turnover would result.

Evidence on interventions

Unfortunately, little empirical research has been conducted on the recruitment and retention of care workers, an issue that must be addressed if organisations are to address staffing difficulties.

Possibly the most comprehensive study that has been undertaken on the community care industry was one in the early 1990s that involved the establishment of four demonstration projects in the United States. These projects were designed to investigate the idea that upgrading community care positions would reduce the turnover of staff. The demonstration projects were assembled from combinations of seven components:

- supplementary training – basic and/or specialised
- supplementary support and/or supervision

- wage increments
- supplementary benefits – health insurance, vacation and/or sick leave
- increased job stability – guaranteed hours and/or full-time work
- status enhancements such as badges, uniforms, job titles
- promotion. (Hollander Feldman 1993)

The projects were known as the Attendant Specialist Program, the San Diego Demonstration, the Staff Aide Demonstration and the HRA Field Support Liaison Program. The main outcome measure used was turnover rate, which was compared with the turnover rates of control groups. The respective projects, with their combination of components and outcomes, are summarised in Table 1, where outcome is measured as the percentage difference in turnover between the demonstration and control groups (where a positive percentage indicates a lower turnover).

Table 1 Summary of demonstration project descriptions and outcomes

Program	Components	Outcome
Attendant Specialist Program	• specialised training in specifically defined difficult cases • on-going professional support from the program's trainer • small wage increment • status enhancements (special titles, badges, and program publicity)	+11%
San Diego Demonstration	• supplementary training in basic home care skills • guaranteed thirty-five hour week after completion of training • extra support in small worker groups under the direction of trained professionals • supplementary subsidised health insurance benefits • status enhancements (special jackets and badges)	+21%
Staff Aide Demonstration	• increases in hourly wages • enhanced fringe benefits, including health insurance, retirement pay, and vacation and sick leave • increased supervision and informal peer support • guaranteed full-time work • status enhancements	+44%
HRA Field Support Liaison Program	• supportive in-home visits from former peers - Field Support Liaisons – to provide support and to assist in the solving of a variety of problems	+10%

The combined results of these four demonstrations indicated that work life improvements positively impacted the turnover rate of employees, who in turn gained higher self-esteem, higher morale and increased loyalty to their employer (Hollander Feldman 1993). Unfortunately, the results also demonstrated that the implementation of work life improvement programs could be quite expensive; and as the funding for the projects eventually ceased, all agencies returned to their previous employment practices (Stone & Wiener 2001).

Some states in the US have experimented with the development of new pools of workers. One study evaluated a program, targeted at various disadvantaged groups, that provided free training, child care and uniforms, and transportation assistance (Filinson 1994, cited in Stone &Wiener 2001). It was found that the most successful trainees were those not receiving public assistance at the onset of training, particularly homemakers recovering from divorce, the recently unemployed and new immigrants. The study concluded that the training was inadequate for

those more permanently removed from the workforce, such as people who had experienced long-term unemployment (Filinson 1994, cited in Stone &Wiener 2001).

A government initiative in the US to address low pay has been the ‘wage pass-through’. Under this scheme the state orders that some portion of reimbursement increases for public-funded long-term care must be used specifically to increase wages or worker benefits. Unfortunately, whilst the wage pass-through has been employed by many agencies, little data exists on its effectiveness to increase worker retention (Stone & Wiener 2001). Incentives have also been tried, with wages dependent on characteristics such as the level of client and worker satisfaction, level of client disability, and weekend/evening work. Also being explored are schemes that provide improved benefits for workers such as health insurance, transportation subsidies and career ladders (Stone & Wiener 2001). Unfortunately, empirical evidence about the effect of these initiatives is not yet available.

To address the concern that a negative image was impacting on the recruitment and retention of long-term care workers, an area in the US implemented a marketing campaign involving mailing postcards; placing advertisements in newspapers, on radio and on billboards; distributing posters; placing information on payroll slips; and distributing notepads/note cards. They targeted newly retired and recently widowed adults, students, retail and food-service workers, and homemakers. Research suggested that the campaign may have increased retention rates and improved employee attitudes, but was less effective in recruiting new workers. Interestingly, lower cost marketing techniques (e.g. mailing postcards) were found to be more effective than sophisticated, multi-media advertising (Kenosha County Department of Human Services 2001, cited in Stone & Wiener 2001).

The future

In relation to community care, the challenge that faces Australia is to ensure cost-effective health and social care for increasing numbers of frail older people and people with disabilities, and to do so in an equitable way that delivers high-quality services (Healy 2002). This requires adequate numbers of skilled people being willing to work in the industry; but, given the problems currently facing many organisations, this cannot be assured. It will be necessary to improve the attractiveness of community care employment, particularly to men and to younger people, if we are to meet the growing demand for this type of care.

Clearly there are concerns, both in Australia and overseas, about how the conditions of community care jobs affect people’s willingness to do this type of work. Dawson, Rico and Trocchio (2001) have identified five principles they believe should guide employers of long-term care workers. Firstly, employers should recognise care-giving as a vocation and should value the commitment of workers through measures such as involving them in care planning. Secondly, employers should ensure that workers earn reasonable wages and benefits and are offered ongoing training and development. Thirdly, employers should support workers during personal emergencies. Fourthly, they should identify and change organisational practices that devalue staff (for example by improving the quality of the supervision provided to workers and ensuring that workers have a voice in matters that affect their work lives). Lastly, employers should establish a permanent staff committee with direct care workers at its core in order to gather information, make suggestions and monitor program success. It should be noted that these principles are consistent with basic human resource management recommendations.

In their recent study, VAHEC (2002) concluded that the poor terms and conditions of the industry need to be addressed. Their study recommended that the private community care sector develop a coordinated approach to government and other funding bodies which highlights the need for improved funding to support the direct care workforce in an increasingly complex environment and an increasingly competitive labour market’ (p.4). They also concluded that there was a need to address the industry’s reliance on middle-aged women, and suggested that

the industry be marketed to a diverse range of prospective employees by emphasising opportunities for professional career development and personal satisfaction/achievement. They also suggested that trainee and apprenticeship schemes be further developed in order to attract younger people to the industry. VAHEC (2001) have developed a workforce management strategy to address some of the concerns of the community care industry, with one identified issue being its poor image and profile. DHS has also established a HACC Workforce Development Strategy project to address workforce issues within the community care sector.

There is concern, both locally and overseas, about the difficulties organisations are experiencing with the recruitment and retention of direct care staff. If left unaddressed, these staffing difficulties can be expected to increase, not least because of the ageing of the population and the resulting increase in the number of people requiring community care. Whilst much of the available literature is from the US, and consequently has limited applicability to the Australian community care system, it does point to issues that need consideration in ensuring there are adequate numbers of community care workers into the future.

Results

General information

Respondents

Questionnaires were returned by 159 organisations—59 local councils, 93 not-for-profit organisations and 7 for-profit organisations—which employ paid community care workers. Reponses were also received from 19 organisations that did not employ workers targeted by this research. In total, 178 organisations either completed the questionnaire or informed the project team that it was not applicable to their organisation.

Table 2 Summary of organisations responding to questionnaire

Types of services provided	No. of local councils (Total=59)	No. of not-for-profit organisations (Total=93)	No. of for-profit organisations (Total=7)
Only home care, personal care, and/or respite care	11	23	5
Only planned activity groups, delivered meals and/or home maintenance	1	43	0
Services from both the above groups	47	27	2

Completed questionnaires were received from 115 organisations that provided home care, personal care and/or respite care, and 120 organisations that provided planned activity groups, delivered meals and/or a home maintenance service. A total of 76 organisations completed both sections of the questionnaire, 39 completed only the section about home care, personal care and/or respite care services and 44 completed only the section on planned activity groups, delivered meals and/or home maintenance.

Organisations were asked to indicate the size of their community care budget. This information has not been included in the report as some organisations apparently reported their total budget.

Consideration of where organisations provided services indicates that all DHS regions received reasonable coverage. Not surprisingly, the coverage of the metropolitan regions was generally higher than the non-metropolitan regions. Table 3 shows the percentage of respondents providing services in each DHS region.

Table 3 Respondents, by region in which majority of services are provided (%)

DHS region	% respondents providing services in region
Northern Metropolitan Region	19%
Eastern Metropolitan Region	22%
Southern Metropolitan Region	20%
Western Metropolitan Region	16%
Barwon South Western Region	17%
Grampians Region	12%
Loddon Mallee Region	12%
Hume Region	12%
Gippsland Region	11%

Note: Percentages do not total 100% as some organisations provide services in more than one region, especially in metropolitan Melbourne.

An additional method of assessing whether the responses received reflected the service system across all of Victoria is to consider the 60 responses from local councils (of a possible 78). Whilst the MAV has many methods of classifying councils for different purposes, this research used their method whereby councils were classified as five types: inner metro, outer metro, regional city, large shire and small shire. Table 3 demonstrates that a good response was received from all council types, with the lowest response rate being from small shires (63%). Overall, shires represented 45% of all council responses, metropolitan councils 40%, and regional cities the remaining 15%.

Table 4 Local council respondents, by type

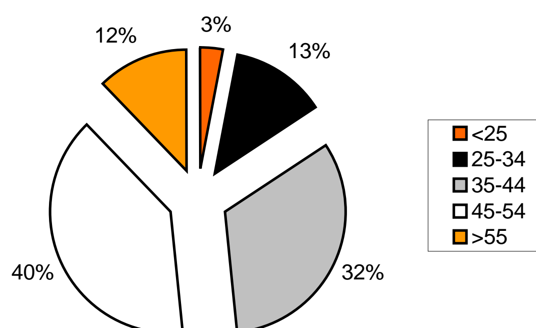
Local council classification	Total no. of local councils	No. of respondents	% respondents
Inner metro	18	15	83%
Outer metro	13	9	69%
Regional city	11	9	82%
Large shire	17	14	88%
Small shire	19	12	63%
Total	78	59	75%

These figures indicate that the survey results should not be skewed markedly by the experiences of organisations providing services in one DHS region or of one council classification. It is also important to note that the experiences of organisations that provide services in metropolitan areas cannot dictate the overall results.

Staff profiles

Respondents to the questionnaire were asked to indicate the age range and gender of their staff. The total number of community care workers reported on was 8,600, of whom 90% were women. More than 50% of workers were aged 45 and over, with a further 32% aged 35 to 44. Information about the age breakdown is presented in Figure 2.

Figure 2 Age profile of community care staff



Respondents confirmed findings from previous studies which found that the community care sector was based on part-time and casual employment. No full-time positions were offered by 85% of organisations. Approximately one-third of organisations offered only part-time positions, whilst approximately 15% recruited only casual staff. Most organisations operated with a combination of part-time and casual staff. Just over 70% of organisations required staff to provide their own vehicle for work, with the majority of these organisations providing some form of reimbursement. Surprisingly, approximately 30% of organisations did not pay staff for time spent travelling between clients.

Waiting lists

Organisations were asked to provide information about whether they had a waiting list of people requiring services. At least one-third of providers of each service type indicated they had a waiting list. Table 5 indicates the percentage of organisations that reported a waiting list for each service type.

Table 5 Organisations with waiting list for services

Service	Organisations with waiting list (%)
Home care	36%
Personal care	33%
Respite care	33%
Planned activity groups	41%
Home maintenance	36%
Delivered meals	36%

Clearly many community care organisations experience service demands that exceed what they can supply.

Unfortunately, the majority of organisations did not indicate what they saw as the main cause of these waiting lists, but from those that did, limitation of funding was the most common response, rather than difficulty of recruiting staff or a sudden surge in client numbers. It should be noted that some organisations are known to manage demand by offering reduced support for individual clients or by refusing to take new referrals for a period of time, instead of keeping a waiting list.

Community care – home care, personal care, respite care

This section of the questionnaire was completed by 115 organisations. Of these, 97 provided home care, 108 provided personal care, 107 provided respite care (in home and community) and 66 provided respite care (overnight). The organisations belonged to three different types, as shown in Table 6.

Table 6 Number of respondents, by organisation type

	Home care providers	Personal care providers	Respite care (h&c) providers	Respite care (o/n) providers	Total respondents
Local government	58	58	58	32	58
Primarily not-for-profit	33	43	42	27	50
Primarily for-profit	6	7	7	1	7

Almost half the organisations (providing information for almost 5,000 staff) supplied details about the hours worked by part-time staff. This information is presented in Table 7.

Table 7 Hours worked by part-time staff

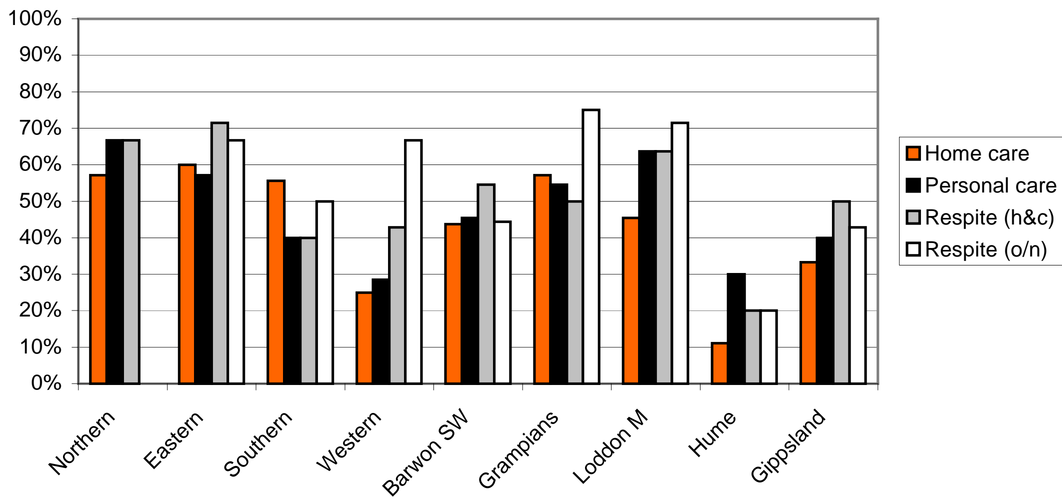
	<10hrs	10-14hrs	15-19hrs	20-24hrs	25-29hrs	30+hrs
Part-time staff (%)	10	5	31	28	14	12

The data indicated that approximately 60% of staff who were part-time worked between 15 and 24 hours per week. It should be noted that only half of the organisations (51%) employed their staff on the basis of a guaranteed minimum number of hours of work per week, with the minimum varying between organisations.

Recruitment

Respondents to the questionnaire were asked to identify whether they had had difficulty recruiting direct care staff within the past 12 months. Recruitment for personal care and respite care services (both in-home and community, and overnight) was a concern for many organisations, with more than 50% of providers of each of these services stating that they had had difficulty recruiting staff. Difficulty recruiting home care staff was experienced by 43% of respondents. This information was analysed further (see Figures 2 to 5) but it should be noted that this meant the number of organisations in categories was often low, limiting the analyses of reliable tests of statistical significance. To assist in the interpretation of the data the numbers of organisations in each category is contained in Appendix 3.

Figure 3 Recruitment difficulty, by DHS region

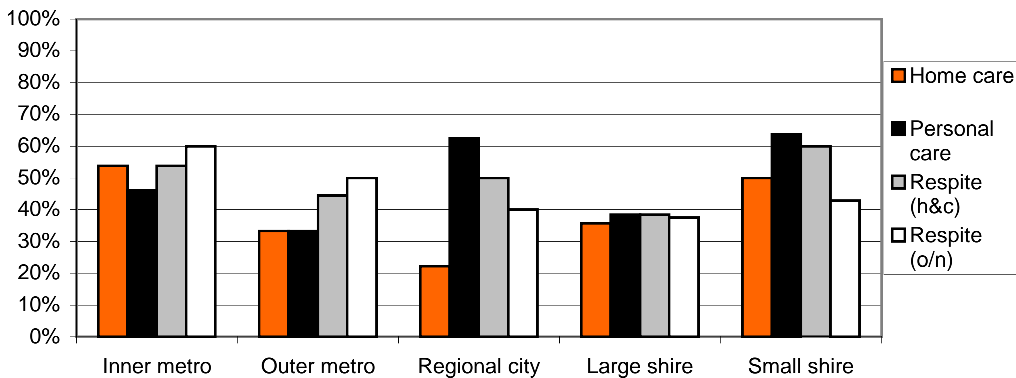


Notes: Respite (h&c) = respite (home and community)
Respite (o/n) = respite (overnight)

By considering only those organisations that provide services in one DHS region, it is possible to explore regional differences in recruitment difficulties. From Figure 3, it appears that those organisations providing services only in the Hume region were less likely to be experiencing difficulties with staff recruitment. Of metropolitan regions, the organisations providing services in the Western region appeared to experience less difficulty recruiting staff than organisations in other areas.

Differences between different types of population centre were also explored. Figure 4 presents recruitment difficulty by council type, using the MAV categories already described (see page 13).

Figure 4 Local council recruitment difficulty, by council type

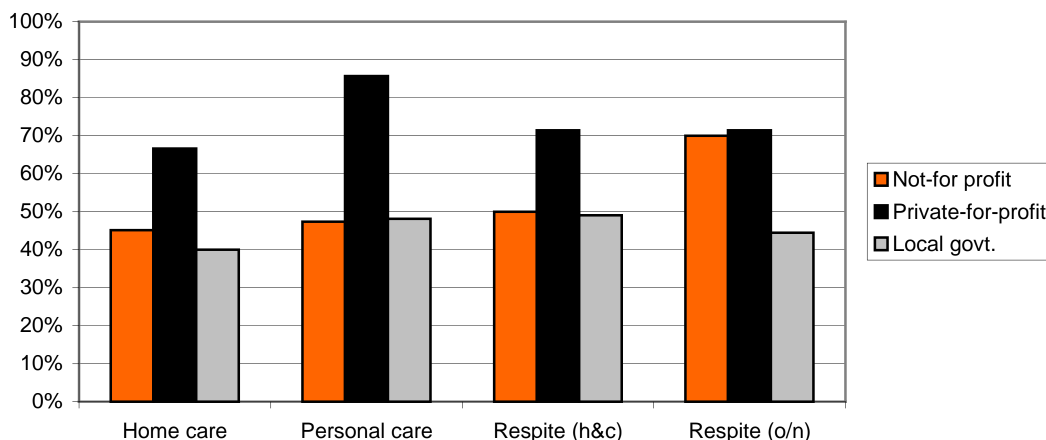


The data suggests that, in general, a smaller proportion of outer metropolitan councils and large shire councils have experienced difficulty in recruiting staff. Regional city councils appeared to have experienced less difficulty in the recruitment of home care staff, whilst small shire councils and inner metropolitan councils experienced considerable difficulty across all service

types. Unfortunately, it was not possible to test for the statistical significance of these differences.

Figure 5 presents recruitment difficulty by organisation type.

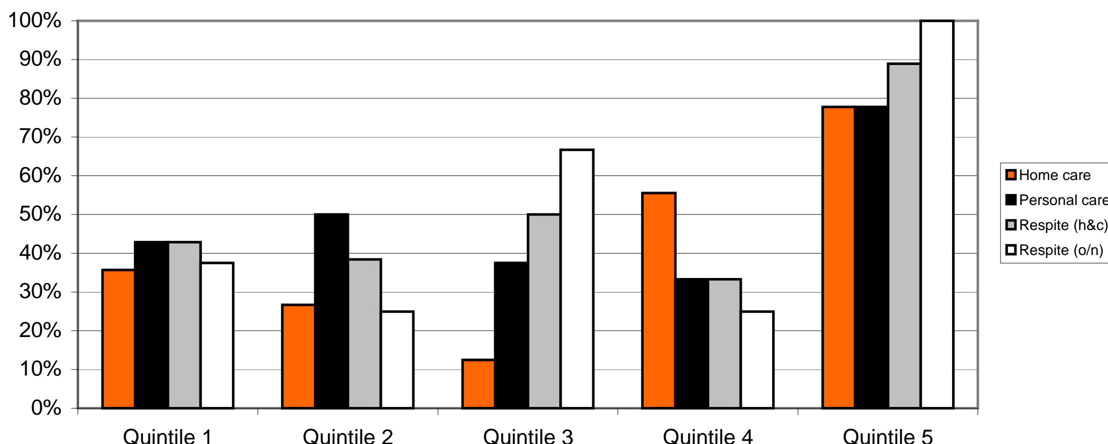
Figure 5 Recruitment difficulty, by organisation type



The frequency data showed that a greater percentage of for-profit organisations experienced difficulty recruiting staff than local councils or not-for-profit organisations (see Figure 5), but due to the small numbers of private for-profit organisations it was not possible to test the statistical significance of this relationship.

From census information it is possible to calculate a measure known as the Index of Relative Socio-Economic Disadvantage (IRSED). Variables included in this index are low income, low educational attainment, unskilled occupations, unemployment, one-parent families, renting households and Aboriginal and Torres Strait Islanders (ABS 1998a). A high score on this index means the area has relatively fewer people with these attributes, while a low score indicates relatively more people with these attributes. The IRSED can be calculated for local government areas (see Appendix 1 for local government IRSED scores based on 1996 Census data, classified into quintiles). Quintile 1 contains local government areas of greatest socio-economic disadvantage; quintile 5 local government areas of least socio-economic disadvantage. Figure 6 presents local councils' recruitment difficulty by IRSED96 quintiles.

Figure 6 Local council recruitment difficulty, by IRSED96 quintiles



The group of councils with least socio-economic disadvantage (quintile 5) appeared to have experienced the greatest difficulty with staff recruitment, with this difficulty being experienced across all service types. Within quintile 4, home care was the service type for which councils

had experienced greatest difficulty with recruitment. A surprisingly small proportion of quintile 3 councils had experienced difficulty recruiting home care staff. Reliable statistical significance testing of these results was not possible.

Of the organisations that reported difficulty with the recruitment of direct care staff, 19% stated that it had been a problem for less than 12 months, 45% for 12-24 months and 36% for more than 24 months. Thus it appears that recruitment difficulties are an on-going problem for many organisations. Not surprisingly, 60% of organisations stated that they had implemented strategies aimed at improving the recruitment of staff (see Discussion).

Organisations having difficulty with recruitment were asked to rank the direct care services according to difficulty to fill. Almost half the organisations ranked personal care positions as the most difficult to fill. This can in part be explained by looking at whether workers are required to have qualifications prior to employment. For personal care, 45% of organisations required workers to hold appropriate qualifications prior to employment ; for respite care, 49% did so; but for home care, only 15% required qualifications. It should be noted that HACC Program guidelines indicate personal care workers should hold a minimum qualification (Certificate III).

Retention

Respondents were asked whether there was concern within the organisation about the level of direct care staff turnover, and approximately 44% of organisations indicated that they were concerned. In a similar manner to that used to consider recruitment difficulties, retention can be analysed on a DHS regional basis, by council type, and by IRSED96 (see Tables 8 to 10).

Table 8 Concern about staff turnover, by DHS region

DHS region	Total respondents	No. concerned	% concerned
Northern Metropolitan	7	3	43%
Eastern Metropolitan	7	2	29%
Southern Metropolitan	10	3	30%
Western Metropolitan	8	1	13%
Barwon South Western	17	8	47%
Grampians	13	4	31%
Loddon Mallee	11	6	55%
Hume	10	4	40%
Gippsland	10	7	70%

Generally, the non-metropolitan regions expressed greater concern about staff turnover than metropolitan regions. Some 70% of organisations in the Gippsland region were concerned about their turnover rate, compared with only 13% of those in the Western Metropolitan region. This pattern was confirmed by the consideration of council types, presented in Table 9.

Table 9 Concern about staff turnover, by council type

Council type	Total respondents	No. concerned	% concerned
Inner metro	13	4	31%
Outer metro	8	1	13%
Regional city	8	5	63%
Large shire	14	6	43%
Small shire	12	4	33%

Regional city councils expressed the greatest concern about turnover rate, at over 60%. Almost half of the large shire councils that responded were also concerned about turnover, as well as

one-third of small shires and inner metropolitan councils. Only 13% of outer metropolitan councils expressed concern.

When the information is considered by IRSED96 quintile, presented in Table 10, the picture is less clear.

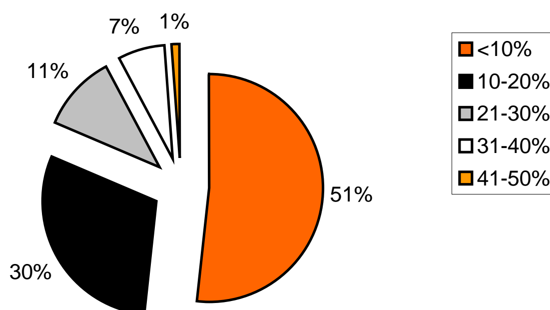
Table 10 Local council concern about turnover, by IRSED96 quintiles

IRSED96 quintile	No. of respondents	No. concerned	% concerned
Quintile 1	13	4	31%
Quintile 2	15	6	40%
Quintile 3	8	2	25%
Quintile 4	10	4	40%
Quintile 5	9	4	44%

The most marked difference is that organisations that delivered services in the highest socio-economic areas (quintile 5) were more likely to indicate concern about turnover than organisations delivering services in quintile 3.

Organisations that were concerned about turnover were asked to indicate the length of time for which it had been a problem. Almost 14% indicated it had been a problem for less than 12 months, 31% reported 12-24 months, and 55% said more than 24 months. Organisations were also asked to estimate the level of direct care staff turnover in the past 12 months, and the results are presented in Figure 7.

Figure 7 Estimate of staff turnover in past 12 months



Approximately half of the organisations reported an estimated turnover rate of less than 10%, whilst half reported a rate greater than 10%. Of particular concern is the fact that about 20% reported a turnover rate greater than 20%. Strategies aimed at minimising the turnover rate have been implemented by 43% of the organisations (see Discussion).

Figures 8 to 11 present turnover rates by DHS region, by local council type and by IRSED96 quintiles (the numbers of organisations are contained in Appendix 4).

Figure 8 Estimate of turnover, by DHS region

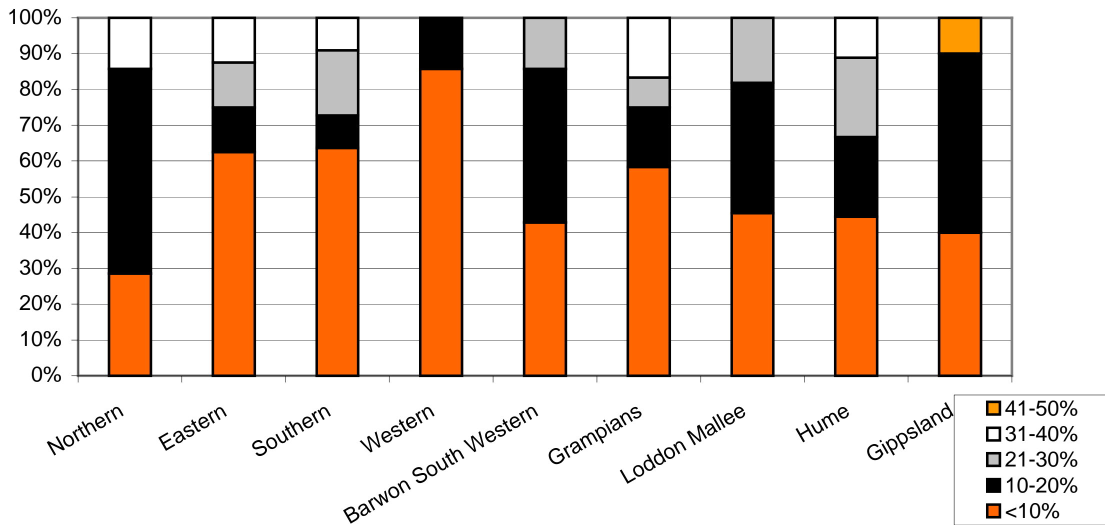
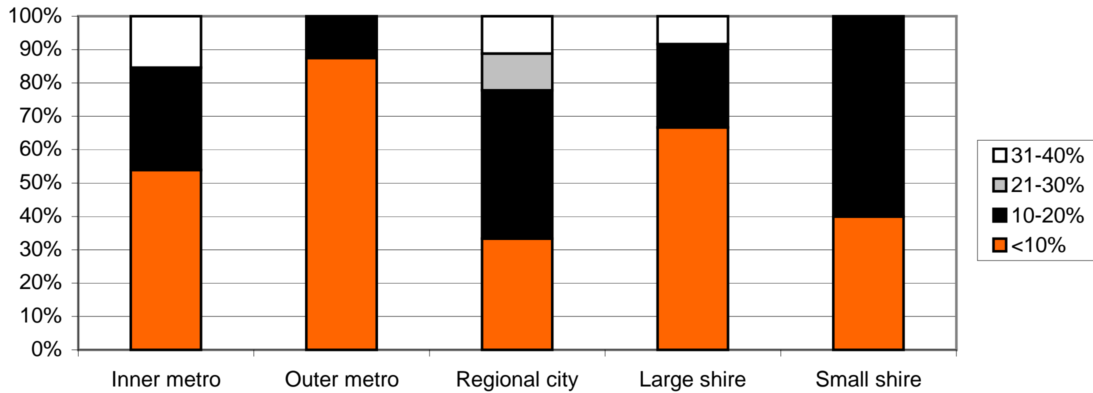
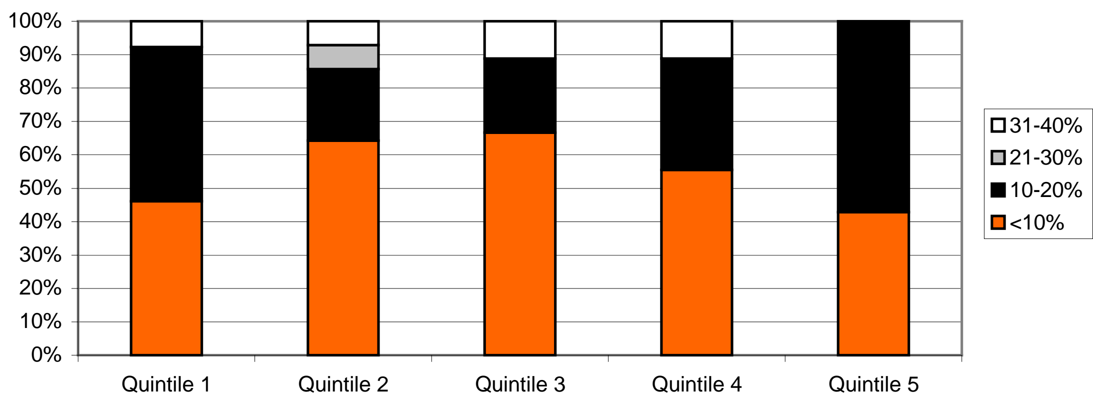


Figure 9 Estimate of turnover, by local council type



Note: Local councils only

Figure 10 Estimate of turnover, by IRSED96



Note: Local councils only

Only one organisation out of seven in the Western Metropolitan region reported a turnover greater than 10%, compared with about 70% of organisations in the Northern Metropolitan region (5 of 7 organisations). Consideration of turnover rate by council type suggests that outer

metropolitan councils have experienced lower turnover rates (almost 90% reported a rate lower than 10%). Regional city councils appeared to have the greatest concern with turnover, with more than 65% reporting a rate greater than 10%. Of the regional city councils, more than 20% reported a turnover of greater than 20%. From Figure 10 it is difficult to see a clear relationship between estimated level of staff turnover and the IRSED96 quintiles.

Qualifications and training

Community care workers need training in order to be adequately prepared to undertake their jobs, to know how to maintain their own safety and security and to be able to provide high quality service. It might be expected that inadequate training provision would have a detrimental effect on staff recruitment and retention.

Training which leads to a qualification recognised under the Australian Qualifications Framework is provided through the Vocational Education and Training System (VET). The two main sources of funding for this type of training are Commonwealth government funded labour force programs, which include new apprenticeships/traineeships, for people who either do not have a qualification or who are upgrading an existing qualification (upskilling), and state government funded training places in registered training organisations such as Institutes of TAFE. In-service training is also provided by employers or with employer support and is vital as it allows workers to address specific issues such as recently identified occupational health and safety risks.

Organisations demonstrated a high level of commitment to the training needs of staff. Approximately 90% of organisations provided in-service training to staff, 71% supported staff to increase their skills through upskilling workforce programs, 58% utilised State Government-funded training places, and 46% supported new apprenticeships/traineeships.

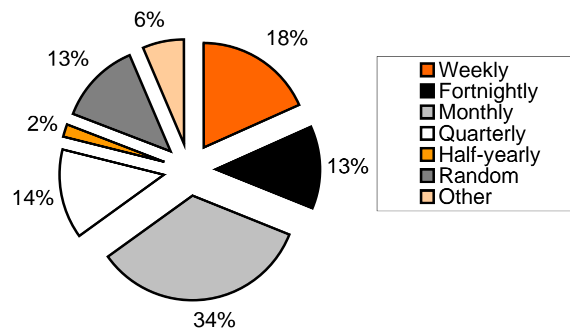
These figures do, however, need to be viewed with some caution. It was not possible to give a detailed explanation of these programs in the survey so it is probable that some people who completed the questionnaire misunderstood the categories. This was most likely to have occurred in relation to the word ‘upskilling’, which has a particular meaning in regard to labour force programs but which could be confused with in-service training by those not familiar with labour force programs. That said, half the surveys returned by providers of home care, personal care and respite care were from local councils, whose staff tend to be more familiar than some non-government organisations with labour force programs and the VET system.

Organisations adopted varied approaches to the employment of qualified/unqualified workers. Some organisations required all workers to have appropriate qualifications prior to employment, others were prepared to employ unqualified staff for all positions and support them whilst they acquired appropriate qualifications. Other organisations adopted a mixed approach, being prepared to employ unqualified workers to provide home care but not personal or respite care. Only a small minority of organisations stated they only recruited qualified staff to provide home care, but almost half of the organisations required qualifications when recruiting for personal care and respite care.

Staff support

Organisations reported wide variety in the frequency of staff meetings or supervision. Figure 11 summarises the frequency of supervision or staff meetings. Again, some caution should be taken with the interpretation of this data for it is possible that some organisations classified minimal contact such as ‘picking up roster’ as a meeting.

Figure 11 Frequency of direct care supervision/meetings



Approximately one-third of organisations met with staff monthly, though some met as regularly as weekly (18%) and others only met on a random or 'as needed' basis.

Slightly more than half the organisations (53%) providing home care, personal care and/or respite care indicated that they offered non-monetary rewards for achievements and contributions. These forms of recognition were more common among the local councils (65%) than among other providers (45%). The most common forms of recognition were:

- certificates of appreciation
- certificates for years of service
- afternoon tea, supper, lunch or dinner
- celebration of Easter, Christmas or other cultural festival
- incentive gifts for ideas, recommending new staff, high quality work or 'extra effort' such as performing on an occupational, health and safety committee.

Planned activity groups, delivered meals, home maintenance

This section of the questionnaire was completed by 120 organisations. Of these, 104 provided planned activity groups, 43 provided delivered meals and 51 provided home maintenance services. The classification of these organisations is provided in the table below. It should be noted that responses were received from less than one-third of all organisations funded to provide planned activity groups.

Table 11 Providers of activities, meals and/or maintenance services, by organisation type

	PAG providers	Delivered meals providers	Home maintenance providers	Total no. of respondents
Local government	37	31	39	48
Primarily not-for-profit	67	12	10	70
Primarily for-profit	0	0	2	2

Note: PAG = planned activity groups

Recruitment

There appeared to be less difficulty recruiting workers for planned activity groups, delivered meals and/or home maintenance than recruiting workers for home care, personal care and/or respite care. In the past 12 months, 13% of providers of planned activity groups had difficulty recruiting staff, with only 6% of home maintenance providers and 5% of delivered meals providers having difficulties.

Of the 13 organisations that were experiencing difficulty with the recruitment of planned activity staff, 7 were in the metropolitan area and 6 were in regional or rural areas. Six of the 7 metropolitan organisations listed low wage rates and/or issues around the hours of work (too few hours or out-of-hours work) as the reasons for this. The reasons listed by the regional or rural organisations were more varied. Wage rates and/or hours of work were given as the reasons for recruiting difficulties by half of the rural or regional organisations. Lack of appropriately qualified people was cited by 2 organisations, whilst the other organisation gave the small rural population as the cause of their difficulty.

Strategies to improve recruitment had been implemented by 28% of organisations that completed this section of the questionnaire (see Discussion).

Retention

Turnover of staff working in planned activity groups, delivered meals and/or home maintenance was not generally perceived to be a problem, as only 7% of organisations (8 of 108) stated that they were concerned by the rate of staff turnover. A staff turnover rate of less than 10% was experienced by over 80% of organisations, with 10% experiencing a rate between 10 and 20%.

Strategies aimed at minimising turnover had been implemented by 18% of organisations (see Discussion).

Qualifications and training

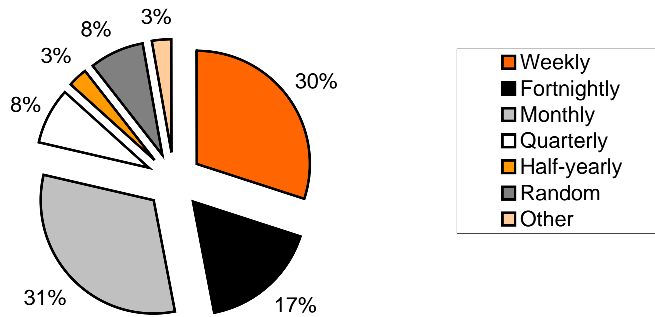
Organisations providing planned activity groups, delivered meals and/or home maintenance also demonstrated a high commitment to the training needs of staff, but provided training less widely

than the providers of home care, personal care and/or respite services. In-service training was most common training type used (84% of organisations), whilst upskilling existing workforce programs was used by 58% of organisations, State Government-funded training places by 45% and new apprenticeships by 21%.

Staff support

Figure 12 summarises the frequency of supervision or staff meetings.

Figure 12 Frequency of other community care supervision/meetings



Staff providing these services generally met with supervisors more frequently than the staff providing the direct care services. Almost 80% of organisations met with staff at least monthly, compared with 65% of organisations providing home care, personal care and/or respite care.

Discussion

The number of people requiring support to remain living at home is challenging Victorian community care organisations, particularly the providers of home care, personal care and/or respite care services. This research has confirmed the perception that a high number of these organisations are having difficulty recruiting and retaining appropriate staff. The number of people requiring support to live in the community will grow markedly over coming decades, placing further strain on organisations and on families unless community care becomes a more attractive employment option.

The data from this research has provided information about the structure of the community care sector and the staffing difficulties that organisations face. It indicates that these difficulties are widespread amongst providers of home care, personal care and respite care, but not so widely experienced by providers of planned activity groups, home maintenance and/or delivered meals. The level of concern in the sector about staffing issues has been quantified, as has the number of organisations implementing strategies to improve these issues. The research has provided some information (outlined below) about these strategies, many of which other organisations may consider implementing as improvements to their own recruitment and retention processes. It is clear that there is concern in the industry about the impact that relatively low wages and sometimes poor conditions have on staffing issues, and the impact of the low status this work appears to have in the community.

Unfortunately, the data has limitations. It was hoped that findings from this research may have identified the most successful strategies, but organisations were not able to provide this level of detail. Some organisations were able to indicate whether they thought particular strategies had been useful, but had not measured their impact. Empirical evidence on workplace initiatives and interventions is rare in the community care field, in Australia or overseas, with much of what has been written being descriptive and anecdotal. Unfortunately, this research largely falls into that category, as the material needed to critically analyse interventions is not available. Through this research we are not able to inform organisations about what actually works, but are only able to give a snapshot of the issues and present ideas from the sector.

In order to improve knowledge of staffing issues in the community care sector it would be useful for organisations to consider a standard approach to measuring turnover rate. In this sector it is not an easy calculation, as the number of positions available within an organisation can vary markedly over a relatively short period of time (being dependent on the numbers of hours being worked by each part-time and casual staff member). It is, however, worth adopting a consistent and intentional approach, particularly in light of the US study that found that organisations significantly underestimated their turnover rate. Having accurate knowledge of the turnover rate and actual worker replacement costs enables an organisation to undertake cost-benefit analyses on strategies that may be implemented to address staffing difficulties. The cost of worker replacement is also not easy to calculate, and was only able to be provided by one organisation interviewed. That organisation calculated it to be $1,100, whilst another organisation estimated it to be about $800. A tool to help organisations calculate the cost of worker replacement can be found at the Women in the Workplace Agency website <www.eowa.gov.au>.

Information about the various strategies that organisations employ to address staff recruitment and retention, selected from both this research (questionnaire and interviews) and the literature, is summarised below.

Job structure

There was variation in how organisations structured their community care positions, but a common factor was that full-time positions were rare. There was concern in some of the

organisations interviewed that full-time work would result in an increased number of work-related injuries (but the organisations interviewed were not able to provide details and there does not appear to be research on this issue). Almost one-third of organisations indicated that all positions were part-time and 15% indicated that all positions were casual. Organisations also indicated that approximately 60% of part-time staff worked between 15 and 24 hours per week. Only 51% of organisations reported that they employed staff with a guaranteed minimum number of hours per week, some organisations offering it formally and others offering it verbally. This can be expected to impact on both the recruitment and retention of workers.

To minimise difficulties with recruitment and retention, organisations should consider having variety and flexibility in the positions they offer. Traditionally, the industry has been based on part-time and casual work, but the questionnaire data and interviews clearly indicated that there were people who wished to work full-time. A number of the organisations interviewed also mentioned that although their workforce was almost entirely permanent part-time, they did have a few staff who chose to work on a casual basis. Some organisations interviewed had an upper limit on the number of hours they would allow a person to perform home care (commonly 15-25hrs), or on the number of days they would allow a person to work due to occupational health and safety (OH&S) considerations.

Recruitment processes

The recruitment process is expensive, which encourages employers to aim to do it well. In order to improve the process, a number of organisations regularly advertise information sessions in the local papers rather than advertise the positions directly. This allows interested people to attend the sessions, gain accurate information about the nature of the work, and then decide if they wish to proceed with an application. A number of organisations interviewed felt that these information sessions helped to reduce the turnover rate, as they rarely led to applications from people who misunderstood what the work entailed.

All organisations interviewed relied heavily on advertisements in local papers to recruit new staff, with only two stating that they had had any success from advertisements in the large daily newspapers. However, whilst most of the organisations interviewed found that advertising in the local papers was their most successful method of recruitment, they also found that they still had trouble attracting appropriate applicants.

Interestingly, there were mixed feelings about word-of-mouth referrals. For some organisations interviewed, word-of-mouth referrals were a very successful method of recruiting staff, so successful in fact that rewards or gifts were provided for appropriate recommendations. Others had less success with this recruitment approach, and abandoned it altogether.

Recruiting through government-funded Job Network providers had not been very successful for any organisations that were interviewed. There was concern about the lack of suitability of the people referred, especially their apparent lack of interest in community care work. Organisations that had employed people referred by these employment agencies found that the people tended to stay only a short period of time.

The ability to offer new apprenticeships or traineeships had assisted recruitment in most organisations interviewed, with some ranking these the most successful method. They enabled organisations to recruit unqualified people, most of whom developed into successful employees. It was apparent from the questionnaire, however, that a few organisations were concerned that after being provided with training and receiving a qualification, some staff resigned to take positions in residential care. Greater knowledge about the movement of workers between community care and residential care is required before it can be concluded that this is a concern for the community care sector.

Staff composition

As other studies have found, the majority of workers in the community care sector were middle-aged women. Whilst no organisation interviewed actually targeted specific groups of people when recruiting, some did express preferences, particularly for a mature-aged workforce. Concern about younger workers was generally expressed in terms of lack of life experience, skills and training, although the difficulty younger people had in gaining client trust and respect was also mentioned. On the other hand, two organisations interviewed relied heavily on younger workers and found them to be diligent, energetic and eager to make a career of community care work.

One council reported that their older workers were reducing their availability for work which increased the recruitment activity of the organisation (e.g. they reduced their work from five to two days per week, increasing the need for the organisation to recruit in order to fill the three-day gap). It should also be noted that two interviewees expressed concern about higher injury rates amongst older workers. From the questionnaire, on the other hand, a number of organisations indicated that their turnover rate was highest among younger employees.

Organisations interviewed felt that for many middle-aged women, community care employment provided a second income and attributed the relative stability of older workers to this fact. Interestingly, two organisations commented that when men enquired about this type of work they rarely proceeded with an application due to the low rate of pay and/or the part-time/casual nature of the work. It must be noted that some workers are relying on community care work for the sole source of their income and often wish to work a higher number of hours or even full-time. Organisations must consider whether they are able to meet this need.

Rewards and recognition

Community care workers are not highly paid, an issue thought by many organisations to have an adverse effect on the recruitment and retention of staff. Indeed, of the 98 organisations that answered the open question 'If there were no budget constraints or other restrictions, what would be the one thing you believe could be done to improve recruitment and/or retention of direct care staff?', just over half nominated improved pay and conditions. This was supported by a number of local councils that stated, either on the questionnaire or when interviewed, that the difficulties of recruitment and retention of staff had decreased since new enterprise agreements had improved the pay and conditions of staff. The questionnaire used in this research did not address pay rates, though the issue was covered in the recent VAHEC (2002) study, which concluded that 'dissatisfaction over low base rates of pay ... and insufficient recompense for out of pocket expenses including travel will lead to attrition of existing employees and discourage new entrants to the industry' (p.4). The fact that community care workers receive relatively low wages will need to be considered in light of the recruitment and retention difficulties already being experienced by employers.

The second most common response (from 29 organisations) to the above question was a general comment about the need to improve the status and recognition of community care work. This issue was raised by most organisations interviewed. They generally believed that management needed to work hard to ensure that staff felt valued, but there was also a need to improve the status of the occupation within the community. VAHEC (2001) have also identified this as an issue in their workforce management strategy.

The questionnaire asked organisations about the non-monetary rewards provided to staff, with approximately half of the organisations indicating that none were provided. The most common forms of recognition were certificates of appreciation, recognition for years of service, morning or afternoon teas, and gifts.

Enhancing the status and recognition of this type of work, possibly within organisations but definitely within the broader community, needs further attention.

Career structure

Approximately 80% of organisations surveyed offered some opportunities for workers to develop their careers, but these opportunities were clearly limited. Of those that provided further information, approximately half indicated that it was generally a case of enabling staff to commence or continue training, with approximately a quarter indicating that staff were then able to upgrade their positions from home care to personal or respite care. Another common strategy was to encourage workers to apply for relieving positions (and permanent positions) within the organisation, such as working with the planned activity groups or assisting with the administrative side of community care work.

A small number of organisations indicated on the questionnaire that they had created new positions, providing some career progression for workers. These positions generally involved providing additional support for workers, often in the field. One rural council is currently implementing the new position of Senior Home Carer which will provide support, advice and training to care workers in the field, as well as providing services to clients.

Almost one-fifth of all organisations surveyed indicated that they were unable to provide much in the way of career opportunities for their community care staff. Organisations interviewed, however, stated that any opportunities to relieve or apply for other positions within the organisation were keenly sought. To deal with this demand from their workers, most organisations that were interviewed stated that they selected their relieving staff on the basis of a resume and an interview.

Staff support

Research undertaken by VAHEC (2002) indicated that ‘feedback from supervisors regarding performance’ was an important issue for workers, yet only two thirds of the organisations surveyed actually had feedback mechanisms in place. In this research, organisations were asked ‘how often staff and/or supervision meetings were conducted’. Two thirds of organisations surveyed indicated they had at least monthly contact with staff, but of concern were the organisations that have contact as infrequently as quarterly, half-yearly or even only randomly. By its nature, community care work is isolating and requires staff to demonstrate considerable initiative and flexibility. To ensure adequate support, staff must have the option to meet regularly with supervisors and other workers.

Organisations vary in the amount of face-to-face contact opportunities with supervisors. Of the contact that does occur, it is often by way of a staff meeting, which may also be combined with a training session. Staff are not necessarily paid for their attendance at all of these meetings and training sessions — some organisations always pay, others pay sometimes and a couple appear to not pay staff at all to attend any meetings or training. To compensate for the lack of opportunities for staff to meet with their supervisor, organisations usually encourage staff to ring if they have any issues to discuss (with some offering 24 hour telephone contact). It is of some concern that a small number of organisations appear to have contact with staff on a ‘need only’ basis. Other organisations, however, have structured their services to allow all staff to meet as regularly as fortnightly, and to be paid to do so.

Unusual for the industry was the daily contact the community care workers at Royal Freemasons’ Homes of Victoria Limited had with their supervisors. These staff met on site at 8am every morning where a handover occurred with their care manager (picking up a basket of supplies and a mobile phone). They returned to the office at the completion of their shift, which was generally of a 6.5 hours duration. One-hour staff meetings were also conducted monthly.

Staff representative committees operated in a number of organisations, meeting on a regular basis with management to discuss issues such as standards and quality of services, innovations, planning issues, and occasionally to make decisions on behalf of the entire staff. One such committee organised Christmas leave rosters, proving beneficial to all. These committees can provide a forum for staff issues to be resolved or work arrangements to be improved.

There is variation in how organisations provide opportunities for staff to meet socially and in how successful they are perceived to be. Some organisations used meetings or training sessions as the only social opportunity, others organised regular out-of-hours events such as dinners or sports. Some organisations took full responsibility for organising events, whilst others relied on staff initiative. The majority of organisations interviewed, however, did put on a Christmas dinner or lunch for staff in recognition for their work.

Rosters and care plans

Limited information was gained from this research about the involvement of direct care staff in care planning for clients, although it was clear that there was considerable variation in how organisations viewed the importance of carers' feedback. Two organisations interviewed had implemented a very formalised approach that required regular written reports from direct care staff (every 4 or 5 weeks), indicating that staff responded well to this involvement. In contrast to this were the organisations that did not include any input from care staff. The questionnaire data indicated, however, that a more common approach was to rely on carers to contact supervisors if they had a concern.

Information about staff involvement in rosters was gained from the organisations interviewed. One organisation required supervisors to meet individually with staff twice yearly, at which time staff were asked to indicate ideas for roster improvements. These changes generally made rosters more efficient. Another organisation reminded staff regularly that they should speak supervisors if they had any suggestions or concerns about their rosters, and two organisations interviewed indicated there was little room for staff involvement in the rosters as clients' preferences always came first.

The involvement of staff input into care planning is an area that could receive greater consideration by some organisations. It would not be unusual that community care workers have greater contact with clients than any other worker, and their input to care planning could be of great benefit. Organisations should consider whether formalising this input would be a way of being seen to value their work. It also makes sense to involve workers in the development and review of their rosters, and is a way of giving them some control over the organisation of their work.

Training

The questionnaire indicated that the majority of organisations were committed to improving the skill levels of their workers. In-service training was the most common form of training, being provided by approximately 90% of organisations. Upskilling, state government funded training places and new apprenticeships/traineeships were also commonly used. Caution, however, needs to be used with the interpretation of the actual figures as there appeared to be confusion within the industry about what training fell into each category.

New apprenticeships or traineeships are clearly a valuable aid for organisations, as they have assisted with the recruitment of staff (the offer of training being used as an employment incentive), and have helped a number of organisations ensure an adequate supply of qualified staff. One organisation interviewed indicated they were unable to avail themselves of traineeships as they never had the number of people their local training provider required to deliver a course at one time, but other organisations did not raise this as an issue.

Organisations do vary, however, on the support they give staff to undertake training. The amount of support from organisations for staff to obtain various qualifications ranged from nil to the full payment of all fees and time to attend (other arrangements fell between these extremes). From the interviews it would appear that obtaining basic qualifications (such as a Certificate III) was more likely to be financially supported by organisations than obtaining higher level ones (such as Certificate IV). One council interviewed, however, valued training highly and paid workers' costs and attendance to obtain higher level qualifications such as Certificate IV or a diploma. Most organisations interviewed paid staff for their time to attend in-service training, but not all (some only paid for attendance at some sessions). One organisation interviewed only paid for client-specific training.

Two organisations interviewed had implemented innovative programs to support staff education. One supported staff to obtain work-related skills such as learn a second language, paid for the course (up to a limit), and often paid staff for their attendance time. They also allowed up to four paid study days per year. Another organisation offered staff the opportunity to learn computer skills in their own time. The organisation provided a trainer to support staff to acquire skills such as word processing, Internet and email.

Case studies

Eleven organisations were interviewed to gain further information about strategies being used by the sector to improve recruitment and retention. To limit repetition, only three have been selected as case studies. These organisations do not necessarily have the very best practices regarding recruitment and retention within the industry, for that is not something that this research could measure. They do, however, represent the detailed work that some organisations have put in to create quality community care positions and to make them an attractive employment opportunity for a broad range of people. Information from other organisations interviewed has been incorporated in the Discussion section of the report.

Royal Freemasons' Homes of Victoria Limited

The Royal Freemasons' Homes of Victoria Ltd is a non-government, not-for-profit provider of aged care services in Victoria with a history spanning 133 years. It provides residential and hostel care and delivers Community Aged Care Packages to frail older people in several inner and eastern suburbs of Melbourne. Royal Freemasons' Homes of Victoria stress the importance of meeting individual needs and preferences in their residential and community care services. They seek the involvement of staff at all levels to assist them in developing and realising their vision for the future.

Recruitment

Royal Freemasons' Homes of Victoria (RFHV) have sites in Carlton, Glen Waverley, Cheltenham and Prahran, and have successfully advertised positions at all these except Prahran in local newspapers. The Prahran site, however, has had greater difficulty with recruitment, and advertisements have been placed in *The Age*, producing average results. Whilst the organisation generally prefers to recruit from the local area, for Prahran they often hire people who travel some distance to work.

The organisation recruits community care workers on an ongoing basis, using their Human Resources/Training Officer to visit the sites regularly and review their needs. They successfully undertook a large recruitment process early last year due to an expansion of their program, and recruited both qualified and unqualified workers. Existing staff assist with recruitment through word-of-mouth, and are offered financial incentives for doing so. This has resulted in the recruitment of many appropriate staff, as referred applicants frequently have the personal traits RFHV desires, even if they have not previously worked in the industry.

To assist with recruitment, RFHV runs information sessions that are advertised through the local papers: 109 people attended the two information sessions held during their last recruitment campaign. Forty-three of these people were recruited, with 35 per cent beginning a traineeship (the remainder had previous experience). Occasionally, the organisation has placed advertisements for staff on university noticeboards and websites, but this has not been very successful. This is despite the fact that some of their staff are students. Recruitment has also resulted from having a stall at the Careers Expo.

Most staff are employed on a permanent part-time basis, with some staff commencing as casuals before moving into permanent part-time roles. Staff are guaranteed up to 32 hours' work, depending on their needs, working approximately 6.5 hours a day, for two to five days per week. The shifts are organised so staff mainly see the same clients each day. The workforce is relatively young and the majority of staff are females. Whilst they have not intentionally targeted recruitment at a younger population, it has produced good results and has given them a dynamic workforce who are generally considering a career in this type of work.

Once staff are recruited, RFHV conducts an extensive induction program. This generally involves a one-day induction to the organisation, their policies and procedures, and a half-day induction to the community care program. Staff who have not previously worked in the industry are 'buddied' with staff at RFHV's hostel for approximately two to four days, or until the hostel staff determine they are competent to work in the community. They also complete a personal care module and accompany existing community care staff for a minimum of two days, again dependent on an assessment of competence. Experienced new staff are also partnered with existing community care staff. New staff are then further supported by either a traineeship and/or by the organisation's internal ongoing training programs. A competency checklist is completed by Care Managers after three months and an experienced worker assesses their work on-site.

Retention factors

The overall turnover of community care workers at Royal Freemasons' Homes of Victoria is less than 4%, with the low number thought to be the result of the detailed recruitment and induction process. If potential new staff are at all unsure about the industry, they are sent out with a community care worker prior to commencement so they can observe what the job is about. In the first six months, less than 10% of new employees leave.

Staff meet with their supervisors (Care Managers) at 8.00am every morning before they begin visiting clients and return to the office at the end of their shift. They are provided with duty lists and pre-packaged medication for individual clients, as well as with mobile phones, enabling them to contact Care Managers and to be contacted should it be necessary.

The staff are involved in the five-weekly review of client care plans, and are generally required to provide written feedback on their clients at least once per week. Workers can also complete a feedback sheet if their Care Managers are not immediately available, raising issues for the Care Managers to follow up.

Site-specific one hour staff meetings are conducted monthly, covering administration issues and training. Workers are also encouraged to discuss any concerns they may have. The training included in the monthly site meetings covers issues such as documentation, internal vision and values, professional boundaries, manual handling, fire safety and health issues such as dementia. This training is either out-sourced or provided by the Training Manager or Human Resources/Training Officer. Training and development plans are based on needs identified from performance appraisals, Care Managers' input, client satisfaction surveys, and other assessment procedures. Whilst each site has an OH&S representative who has attended a five-day OH&S training workshop, OH&S training is also conducted during the meetings. The cost of all team meetings and training is covered by the organisation, and staff are paid to attend.

Untrained staff are supported through traineeships and all staff are encouraged to upgrade their qualifications. Most staff have completed Certificate IV in Community Services, whilst some are undertaking Graduate Diplomas or similar qualifications. RFHV also has an up-to-date Career Pathway folder available to staff, which contains information about nursing, welfare, administration, and case management courses, and the Human Resources Training Officer conducts information sessions about different career options.

The organisation has also implemented a program called the Assistant Care Manager Program, which supports community care workers to undertake some care manager tasks when Care Managers are on leave. Community care workers experience this position under the close supervision of another Care Manager, giving them a sense of whether they would want to pursue a career in this area. This program has been very popular, and staff have to apply for the opportunity to undertake this role.

Community program staff have recently been concerned about some of the effects of their rapid expansion, feeling that there was not a strong unifying workplace culture. Two workshops involving staff were held, resulting in the development of a Value Poster. The staff identified six key values that were important to them as well as the program, and each month staff are nominated by other workers for behaviour that has demonstrated commitment to any of the six values. At staff meetings, the winner is announced and rewarded with movie passes or similar prizes. Although this is a new strategy, initial feedback has been positive.

Staff also undergo a three-month induction appraisal sign-off, and have annual performance appraisals.

Bass Coast Shire Council

Bass Coast Shire Council provides a range of aged and disability services, primarily funded through the HACC Program, for elderly residents, people with disabilities and their carers living in a coastal, largely rural shire about one and a half hours' drive south-east of Melbourne. Priority is given to people who have high support needs, people over 70 years of age and people with a permanent disability where the disability impairs their ability to live independently in the community. Bass Coast Shire is an area of relatively high socio-economic disadvantage.

Recruitment

Bass Coast Shire Council generally advertises vacant community care positions in local newspapers. People submit applications and if considered appropriate are invited to attend an information session, after which those who remain interested in the work are asked to submit a further application. These information sessions are felt to be the most important part of the recruitment process as they help ensure applicants understand the position requirements. Some applications are also received outside the planned recruitment times, and are retained by the Human Resources Department until the next information session, to which suitable applicants are invited. Word-of-mouth referrals are also encouraged, as they have resulted in the employment of a number of high quality workers who have had realistic understandings of the job.

Recruitment strategies used by the Council have also included working with the local job network employment agencies and giving presentations at local TAFE colleges. Unfortunately working with employment agencies has generally been disappointing, with few suitable applications being received. The Council also intends to speak to students at local secondary schools. As young people have limited employment opportunities in the Bass Shire, the Council is hoping that some will consider community care as a career opportunity.

Whilst the Council has not deliberately set out to recruit young people, they strongly encourage young people to apply and like to give them a chance. Approximately 20% of community care staff at Bass Coast Shire Council are aged under 30 years. These younger workers have generally been well accepted by clients, with difficulties only arising where they have lacked confidence.

Community care at Bass Coast Shire Council is administered from the Wonthaggi office, though smaller offices are located at Inverloch, Cowes and Grantville. In order to minimise travel, staff are assigned work in areas close to their homes. Many of the employees are women, earning the sole income of the family. Staff are initially employed on a casual basis but are moved to permanent part-time after three months, unless they elect not to do so or are not suitable for the position. Casual workers tend to work between 15 and 20 hours per week (not guaranteed), and a few permanent staff elect to work full-time (38 hours per week).

New staff attend two days of induction, with the first day covering both organisational information and aspects of the community care role. Issues covered include duty of care, OH&S (e.g. posture, use of chemicals and correct use of equipment) and confidentiality. Unqualified staff are also enrolled in a Certificate III course. On day two, workers are partnered with an experienced worker and visit clients' homes to be instructed 'on the job'. Where necessary, this 'buddying' role continues for more than one day.

Retention factors

The turnover rate of the Bass Coast Shire Council's community care staff is estimated to be between 10% and 20% per year, with the majority of staff staying a number of years. Few staff leave within the first six months of employment.

Time is spent with both clients and staff in order to educate them regarding the importance of the community care roles. During the induction program, it is emphasised to staff that they are professionals, who go into a client's home not only to clean and shop but also to monitor their health and well-being. It is stressed that staff must develop excellent communication skills, need to be well presented, and need to be confident about what they are doing. All staff are provided with a uniform, satchel, manual, and safety equipment.

All community care staff are required to have completed a minimum qualification of Certificate III, and if they have not yet obtained this they are enrolled in the course when they commence employment. Bass Coast Shire Council organises Certificate III training to be provided by the local TAFE (approximately twelve staff are placed on traineeships each year). Workers are paid for their time to attend Certificate III training. Whilst staff are then encouraged to complete Certificate IV, the Council is unable to cover these costs. All staff provide the range of home care, personal care and respite care services as required. However, as the majority of available work is home care, the personal care and respite care work is shared across all workers who have completed the personal care component of Certificate III. Workers are paid different rates for the different types of work they undertake.

The Council conducts monthly in-service training for community care staff, alternating the venue between the Phillip Island and Wonthaggi offices (a bus is provided to transport staff between areas). A certain number of these sessions are considered compulsory and staff are paid to attend. Unfortunately, budget limitations resulted in the Council being unable to pay staff to attend every training session, but they have found that the majority of staff attend all training sessions, paid or not. These evening sessions run over two hours, with the first thirty minutes covering administration issues and general information sharing. An hour is spent on the actual training topic, which is followed by supper and networking for the final thirty minutes. Staff are encouraged to become involved in the presentation of topics. Staff also attend various training sessions offered on the HACC Program's Regional Training calendar.

Due to funding limitations, the Bass Coast Shire Council has ceased conducting fortnightly meetings between staff and supervisors, but staff are aware that they can call on twenty-four hour assistance whenever it is required. They meet supervisors at the monthly in-service training, but are also encouraged to call and make an appointment if they need to see someone outside this time. Staff are in the process of organising weekly or fortnightly meetings (part social and part support) for themselves, and whilst the Council cannot pay for attendance at these meetings, it will support workers by making a venue available. The first social night was held recently and was very well attended. It is intended that these gatherings will be a regular event held in each of the four main towns in Bass Coast Shire.

The Bass Coast Shire Council encourages workers to pursue opportunities to further their careers. Many community care staff have gained other positions within the Council. The three current community care service coordinators were all formerly care workers, as were the payroll officer, the previous OH&S officer, the current OH&S officer/workplace trainer, and the planned activity group assistant. Some staff are given the opportunity to work in the office or in the planned activity program when people are on leave.

In recognition of the training and support that is given to staff, the Council last year won the Community Services and Health Industry Training Award for Employer of the Year in creating a learning culture. In 2000 they were runner-up for the Victorian Training Award. They have also won a National Award for Local Government for Innovations in Organisational Practice. When the award was announced last year, the Council and the TAFE college placed a one-page advertisement in the local newspaper, listing every worker's name and emphasising the fact that all staff were qualified. A celebratory cocktail party was held in recognition of the quality of the work of all the community care staff.

Manningham City Council

The Manningham Council's Aged and Disability Support Services provide a range of services to assist frail older people, people with physical, functional, sensory, intellectual or psychiatric disabilities, their carers and families living at home or in the community. The services provided are primarily funded as part of the Home and Community Care Program. Manningham City Council serves a relatively affluent area in eastern suburban Melbourne.

Recruitment

Manningham City Council undertakes quarterly planned recruitment programs for community care workers, and when necessary, supplements this with advertising at other times. They have found that the most successful recruitment program generally occurs early in the calendar year. Recruitment is an ongoing issue for the Council as they are finding that, as well as replacing staff who are leaving, they need to recruit additional staff to cover the hours of older workers who are reducing their availability from five days to two or three per week.

To recruit community care staff, the Council relies heavily on the use of local newspapers, word-of-mouth referrals, and on reputation. They advertise in the Manningham local newspaper, as well as in neighbouring local newspapers. A trial advertising in *The Age* indicated that the results did not justify the cost. Word-of-mouth referrals are definitely encouraged and have attracted appropriate staff. Council staff also make regular presentations at seminars and conferences, and whilst this is not a direct recruitment strategy it helps raise the Council profile as a preferred employer.

Job vacancies are also advertised on the internal website and through the internal weekly newsletters that are provided to all Manningham City Council staff. Fortnightly external newsletters that are distributed throughout the local primary and secondary schools have also been used when new employees are required. The Council profiled their services and staff needs on a Greek radio station, but unfortunately this strategy did not result in any enquiries. When required, Manningham City Council also use a private personnel recruitment agency, as past experiences with government-funded employment agencies have been unsuccessful. They are reluctant, however, to use recruitment agencies because of the high costs involved.

Another method of recruitment that has been trialed was to set up a display in a large local shopping centre. This was unsuccessful, resulting in few responses. Presentations to students in TAFE colleges have also been unsuccessful for recruitment, as the majority of suitable students are already employed or doing traineeships. The Council, however, still continue to run displays at local TAFE college open days, not only to publicise community care as a career option for younger people, but also to attract parents.

Information sessions form an important part of the recruitment process, providing people with accurate information about what community care work actually involves. After the information session, interested people are asked to submit an application for the position. Mandatory for employment are a car, and successful police and medical checks. To speed the recruitment process, the police and pre-employment medical checks are conducted for those applicants who generally meet the selection criteria, and final evaluation occurs at the completion of all checks required for employment. Unqualified people can be recruited for general home support (i.e., home care) as the Council will support them to obtain a Certificate III qualification. People recruited for specific home worker positions (i.e., in personal care or respite care) do, however, need Certificate III training or equivalent, and/or significant experience.

Manningham City Council conducts a four-day compulsory induction program for new employees. The first day covers general council information, as well as position specific issues such as policies, procedures, OH&S, and administration overviews. From day two, new workers

are buddied with senior home support workers, and will generally be placed with two or three different workers so that they experience different styles and approaches. At the conclusion of the induction process, an evaluation session is conducted to assess the employee's ability to perform work duties independently. This process includes information from team administrators, the health and safety officer, senior home support workers and clients.

Retention factors

The overall turnover rate of community care staff at Manningham City Council is low, as is the rate among new staff within the first few months of employment. The Council attributes this, in part, to the success of the information sessions, which help ensure applicants have a realistic understanding of the work. The Council is committed to trying to keep the turnover rate low, not least because they have calculated the cost of staff replacement to be approximately $1100 per person. Key to their management of the community care service is the creation of a professional environment for workers, a factor they believe also contributes to the low turnover rate.

The Council have a combination of 'core-hour' and 'non-core hour' staff, at a ratio of approximately 30:70. Staff work either in general home support (home care) or as specific home care workers (personal care and respite care), and have different job descriptions as well as different rates of pay. The Council believe this is the best strategy in terms of OH&S, as they know that staff are being assigned appropriate tasks, and are given the correct training, monitoring and supervision. From experience, Manningham City Council prefers a more mature workforce. They have found that, in general, younger workers do not have adequate experience, skills and/or training for the community care roles. It is felt that mature workers best serve the needs of clients, and gain greater client acceptance.

Manningham City Council pays for unqualified staff to obtain Certificate III through their training provider: this includes paying staff for the time to attend. Beyond this, staff are encouraged to obtain their Certificate IV qualification, although currently most further training is related to specific clients' needs. As the Council does not operate any residential care facilities there is little opportunity for career development outside the community care service. They have recently created a new pilot program that supports general home support workers to become specific home carers (enabling them to provide personal care and respite care). They have found, however, they have few general home support workers who are interested in upgrading their skills.

The Council provide an innovative program for workers called the 'Learning Network'. This program, which is provided free of charge, enables workers to develop computer-related skills such as word processing, Internet and e-mail use. As this is a personal development program, unrelated to their immediate work environment, it is unpaid and not mandatory.

Workers have face-to-face contact with their team administrators each week when collecting rosters, and there is provision within the rosters to allow for training or meetings. Meetings can be seen to provide social opportunities for workers, with the Council often providing refreshments such as cakes and sandwiches. Staff appraisals are also conducted annually and staff are assessed regularly in the field on their work techniques, undergoing further training if required. General meetings, attended by all staff, are run twice per year: these are used as an opportunity for staff to discuss worker issues only, although feedback from staff has indicated that they want the meetings to include client-specific issues and be conducted more frequently. All staff are paid to attend meetings as well as any briefings that may occur. There is also a staff representative committee that meets quarterly, helping ensure that worker concerns and suggestions are voiced.

Manningham City Council runs general employee satisfaction surveys, but is about to conduct a survey that is focussed specifically on the recruitment and retention issues of community care workers. They are particularly interested in understanding what makes a worker stay with the organisation, as well as why staff may be considering leaving. This information will be used to improve the management of their community care workforce.

Conclusion

The primary aim of this project was to investigate and publicise the type and extent of work being undertaken by community care providers to improve the recruitment and retention of direct care staff. This broad aim has largely been achieved. A range of strategies and innovations have been identified that are worthy of consideration by organisations wishing to improve their own recruitment and retention processes and outcomes.

After receiving funding for the project, a literature review was added to the project design in order to identify any available evidence on effective approaches to improve recruitment and/or retention of community care staff. Unfortunately, even though many other countries are clearly concerned about these issues, very little empirical evidence exists about what actually makes a difference. Unfortunately, this study was also unable to quantify the effectiveness of any particular strategies, as the data was not available. This lack of empirical evidence may make it more difficult for organisations to justify the implementation of any major reform in their processes or practices, as the benefits are uncertain.

Important additional outcomes of this research were the information it provided about the community care workforce and the extent and nature of the recruitment and retention difficulties being experienced by providers. As earlier Australian studies have suggested, the current workforce consists predominantly of middle-aged women employed on a part-time or casual basis, but over the next couple of decades the size of this pool of labour is forecast to decrease relative to the size of the older population. This study confirmed that a relatively large number of organisations are already experiencing difficulties with recruiting and retaining suitable workers (particularly workers who provide services in clients' homes), a situation that is likely to worsen unless community care work becomes more attractive to other pools of workers. Organisations will therefore need to consider strategies that attract younger people, including men, to this field of work. A careful consideration of the impact of employment arrangements (full-time, part-time or casual), including guaranteed minimum hours, should be undertaken by all organisations in the industry.

This study did not set out to investigate the pay and conditions of workers, but a large amount of qualitative data reflected the opinion that better rates of pay would assist in the recruitment and retention of staff. In addition, the practice of not paying for travel time between clients and for time spent at meetings and training needs to be carefully reviewed. Organisations need to consider the adequacy of the pay and conditions of community care workers, particularly in light of the possible staffing difficulties predicted over the next two decades. Changes in pay and conditions may, however, have implications for government funding programs.

The literature, and to some extent, this research, indicates that greater consideration also needs to be given to the work environment and job satisfaction of community care jobs. It is suggested that workers need to be adequately supported, need to be involved in the care planning for clients and need to have input into how their work is structured (such as rosters). Human resource management literature suggests this is a constructive approach. Whilst some qualitative data was collected on these issues, empirical evidence of the impact of these quality-of-work approaches unfortunately does not appear to exist. To assist in addressing this, organisations need to reconsider the type of information they collect about their community care workforce, and how they measure and analyse this information. Only by being better informed will the industry have the necessary knowledge to meet present and future staffing challenges posed by the ageing of the population.

This project identified a number of issues that require more substantial investigation, particularly empirical research. Topics for further research include:

- What factors within and outside an organisation actually impact on recruitment and retention, and to what extent?
- How are successful recruitment and retention interventions best measured? How sustainable are they? How replicable are they?
- What measures can be taken to expand the pool of people willing to undertake community care work? What interventions are needed to attract, train and support currently unemployed people to this field of work? What could be done to increase the number of people employed (and retained) via employment agencies?
- What strategies could be implemented to improve the image and status of the industry?
- What relationships are there between the age of workers, the number of hours worked, and OH&S issues?

Organisations do differ in how they recruit, whom they recruit and how they reward and support their staff. Given how common staffing difficulties are being experienced across the sector it would be useful for organisations to rethink their processes and attitudes. How to make community care work a more attractive employment option for a larger number of people—including men and younger people—must become, if it is not already, a primary concern for the industry.

Appendix 1 IRSED96 categories

These classifications were formed from figures derived from the Index of Relative Socio-Economic Disadvantage from the Census data in 1996. The IRSED is derived from characteristics such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations. It is calculated initially for collector districts, which can be combined to construct a score for various different geographic areas. The IRSED96 scores used in this classification were based on local government areas. Quintile 1 represents the local government areas with the highest socio-economic disadvantage, whilst Quintile 5 represents the local government areas with the lowest socio-economic disadvantage.

Table A Local government areas classified by IRSED96 categories

Quintile 1	Quintile 2	Quintile 3
Ararat	Ballarat	Alpine
Bass Coast	Colac–Otway	Baw Baw
Brimbank	Delatite	Buloke
Central Goldfields	Glenelg	Campaspe
Darebin	Greater Bendigo	Frankston
Greater Dandenong	Greater Shepparton	Gannawarra
Hepburn	Greater Geelong	Golden Plains
Hume	Hindmarsh	Melton
La Trobe	Hobsons Bay	Mitchell
Maribyrnong	Loddon	Moonee Valley
Mildura	Moira	Mornington Peninsula
Moreland	Swan Hill	Northern Grampians
Mount Alexander	Warrnambool	Southern Grampians
Pyrenees	Whittlesea	Wangaratta
Strathbogie	Wodonga	Wellington
	Yarra	West Wimmera
Total 15	Total 16	Total 16

Quintile 4	Quintile 5
Cardinia	Banyule
Casey	Bayside
Corangamite	Boroondara
East Gippsland	Glen Eira
Horsham	Knox
Indigo	Macedon Ranges
Kingston	Manningham
Melbourne	Maroondah
Moorabool	Monash
Moyne	Nillumbik
Murrindindi	Queenscliffe
Port Phillip	Stonnington
South Gippsland	Surf Coast
Towong	Whitehorse
Wyndham	Yarra Ranges
Yarriambiack	
Total 16	Total 15

Source of IRSED96 data: Census 1996

Appendix 2 Classification of local council types

These classifications and population figures were provided by the MAV, and are just one of a number of methods the MAV uses to classify local councils.

Table B Victorian councils, type and population size 2001

Inner metropolitan	**Outer metropolitan**	**Regional city**
117,400 Banyule	162,700 Brimbank	78,800 Ballarat
85,100 Bayside	45,400 Cardinia	91,000 Greater Bendigo
150,200 Boroondara	183,000 Casey	195,000 Greater Geelong
125,800 Darebin	121,800 Frankston	57,400 Greater Shepparton
117,200 Glen Eira	130,100 Greater Dandenong	18,200 Horsham
80,000 Hobsons Bay	132,900 Hume	72,900 La Trobe
131,900 Kingston	141,100 Knox	49,100 Mildura
115,100 Manningham	48,200 Melton	21,200 Swan Hill
63,400 Maribyrnong	123,300 Mornington Peninsula	25,200 Wangaratta
94,200 Maroondah	59,300 Nillumbik	28,900 Warrnambool
43,100 Melbourne	117,700 Whittlesea	36,000 Wodonga
161,200 Monash	90,100 Wyndham	
106,900 Moonee Valley	139,800 Yarra Ranges	
134,400 Moreland		
68,900 Port Phillip		
84,600 Stonnington		
140,700 Whitehorse		
63,300 Yarra		
Total 18	Total 13	Total 11

Large shire	**Small shire**
37,600 Baw Baw	11,800 Ararat
36,700 Campaspe	13,000 Alpine
21,800 Colac Otway	23,000 Bass Coast
17,600 Corangamite	8,500 Buloke
21,600 Delatite	13,800 Central Goldfields
42,600 East Gippsland	12,600 Gannawarra
21,100 Glenelg	16,400 Golden Plains
37,900 Macedon Ranges	15,400 Hepburn
29,900 Mitchell	6,900 Hindmarsh
27,400 Moira	15,600 Indigo
30,000 Moorabool	10,000 Loddon
16,600 Moyne	18,100 Mount Alexander
13,900 Murrindindi	14,000 Northern Grampians
17,200 Southern Grampians	7,200 Pyrenees
27,700 South Gippsland	3,300 Queenscliffe
19,600 Surf Coast	9,800 Strathbogie
43,700 Wellington	6,600 Towong
	5,300 West Wimmera
	8,800 Yarriambiack
Total 17	Total 19

Source of population data: DOI estimates, *Victoria in Future 1996-2021*

Appendix 3 Recruitment difficulty data

Details of responses about recruitment difficulty are provided here. Totals vary, as not all organisations responded to these questions.

Table C presents the number of organisations which are having difficulty with recruitment in home care, personal care, or respite care, and only provide this service within one particular region. The total is the number of organisations which provide that particular service within the region. For example, 4 out of the 7 organisations that provide home care in the northern area only are experiencing difficulty with recruitment.

Table C Recruitment difficulty, by DHS region

	Home care		Personal care		Respite care (h&c)		Respite care (o/n)	
	No.	(Total)	No.	(Total)	No.	(Total)	No.	(Total)
Northern	4	(7)	4	(6)	4	(6)	0	(0)
Eastern	3	(5)	4	(7)	5	(7)	2	(3)
Southern	5	(9)	4	(10)	4	(10)	3	(6)
Western	2	(8)	2	(7)	3	(7)	2	(3)
Barwon South Western	7	(16)	5	(11)	6	(11)	4	(9)
Grampians	4	(7)	6	(11)	4	(8)	3	(4)
Loddon Mallee	5	(11)	7	(11)	7	(11)	5	(7)
Hume	1	(9)	3	(10)	2	(10)	1	(5)
Gippsland	3	(9)	4	(10)	4	(8)	3	(7)
All regions	34	(81)	39	(83)	39	(78)	23	(44)

Note: *Total* numbers are low due to the exclusion of organisations which provide services in more than one region. This was done in order to ensure meaningful comparisons between DHS regions.

Table D presents the number of local government organisations, classified by local council type (see Appendix 2), which are having difficulty with recruitment in home care, personal care, or respite care. The total is the number of organisations which provide that service within the particular area. For example, 7 out of the 13 councils that provide home care in the inner metro area are experiencing difficulty with recruitment.

Table D Local council recruitment difficulty, by type

	Home care		Personal care		Respite care (h&c)		Respite care (o/n)	
	No.	(Total)	No.	(Total)	No.	(Total)	No.	(Total)
Inner metro	7	(13)	6	(13)	7	(13)	3	(5)
Outer metro	3	(9)	3	(9)	4	(9)	1	(2)
Regional city	2	(9)	5	(8)	4	(8)	2	(5)
Large shire	5	(14)	5	(13)	5	(13)	3	(8)
Small shire	5	(10)	7	(11)	6	(10)	3	(7)
All types	22	(55)	26	(54)	26	(53)	12	(27)

Note: Not all councils responded to this question.

Table E presents the number of organisations, of each organisation type, which are having difficulty with recruitment in home care, personal care, or respite care. The total is the number of organisations of each type which provide that particular service. For example, 22 out of the 55 local government organisations that provide home care, are experiencing difficulty recruiting.

Table E Recruitment difficulty, by organisation type

	Home care		**Personal care**		**Respite care (h&c)**		**Respite care (o/n)**	
	No.	(Total)	No.	(Total)	No.	(Total)	No.	(Total)
Local government	22	(55)	18	(54)	26	(53)	12	(27)
For-profit	4	(6)	6	(7)	5	(7)	5	(7)
Not-for-profit	14	(31)	26	(38)	16	(32)	14	(20)
All types	40	(92)	50	(99)	47	(92)	31	(54)

Note: Not all organisations responded to this question.

Table F presents by quintiles of relative socio-economic disadvantage (measured by IRSED96) the number of local government organisations, which are having difficulty with recruitment in home care, personal care, or respite care. The total is the number of local government organisations which provide that service within a area belonging to a particular quintile. For example, 5 out of the 14 local government organisations that provide home care in the areas with the highest socio-economic disadvantage (Quintile 1), are experiencing difficulty recruiting.

Table F Local council recruitment difficulty, by IRSED96 quintiles

	Home care		**Personal care**		**Respite care (h&c)**		**Respite care (o/n)**	
	No.	(Total)	No.	(Total)	No.	(Total)	No.	(Total)
Quintile 1	5	(14)	6	(14)	6	(14)	3	(8)
Quintile 2	4	(15)	7	(14)	5	(13)	2	(8)
Quintile 3	1	(8)	3	(8)	4	(8)	2	(3)
Quintile 4	5	(9)	3	(9)	3	(9)	1	(4)
Quintile 5	7	(9)	7	(9)	8	(9)	4	(4)
All quintiles	22	(55)	26	(54)	26	(53)	12	(27)

Notes: Quintile 1 represents the local government areas with the highest socio-economic disadvantage, whilst Quintile 5 represent the local government areas with the lowest socio-economic disadvantage. Not all organisations responded to this question.

Appendix 4 Estimates of staff turnover

Details of responses about staff turnover are provided here. Totals vary, as not all organisations responded to these questions.

Table G presents estimate of their own staff turnover from organisations which provide services within one particular DHS region. For example, 2 out of the 7 organisations that provide services in the northern region only estimate their staff turnover to be less than 10%.

Table G Organisations' estimate of staff turnover, by DHS region

	<10%	10-20%	21-30%	31-40%	41-50%	Total in region
Northern	2	4	0	1	0	7
Eastern	5	1	1	1	0	8
Southern	7	1	2	1	0	11
Western	6	1	0	0	0	7
Barwon South-Western	6	6	2	0	0	14
Grampians	7	2	1	2	0	12
Loddon Mallee	5	4	2	0	0	11
Hume	4	2	2	1	0	9
Gippsland	4	5	0	0	1	10
All regions	46	26	10	6	1	89

Note: Totals are low due to the exclusion of organisations which provide services in more than one region. This was done in order to enable meaningful comparisons between DHS regions. Not all organisations responded to this question.

Table H presents estimate of their own staff turnover from local government organisations, classified by council type (see Appendix 2). For example, 7 out of the 13 local councils that are located in the inner metropolitan region estimate their staff turnover to be less than 10%.

Table H Local council estimates of staff turnover, by type

	<10%	10-20%	21-30%	31-40%	Total number in type
Inner metro	7	4	0	2	13
Outer metro	7	1	0	0	8
Regional city	3	4	1	1	9
Large shire	8	3	0	1	12
Small shire	4	6	0	0	10
All types	29	18	1	4	52

Note: Not all councils responded to this question.

Table I presents estimates of their own staff turnover rates from organisations classified by organisation type. For example, 29 out of the 52 local government organisations estimate their staff turnover to be less than 10%.

Table I Estimate of staff turnover, by organisation type

	<10%	10-20%	21-30%	31-40%	41-50%	>50%	Total in type
Local government	29	18	1	4	0	0	52
For-profit	1	2	3	1	0	0	7
Not-for-profit	21	13	9	2	1	1	47
All types	51	33	13	7	1	1	106

Note: Not all organisations responded to this question.

Table J presents estimates of staff turnover from local government organisations, classified by IRSED96 quintiles. For example, 6 out of the 13 local government organisations in the areas classified as having the highest socio-economic disadvantage (Quintile 1) estimate their staff turnover to be less than 10%.

Table J Local council estimates of staff turnover, by IRSED96 quintiles

	<10%	10-20%	21-30%	31-40%	Total number in quintile
Quintile 1	6	6	0	1	13
Quintile 2	9	3	1	1	14
Quintile 3	6	2	0	1	9
Quintile 4	5	3	0	0	8
Quintile 5	3	4	0	1	8
All quintiles	29	18	1	4	52

Note: Quintile 1 represents the local government areas with the highest socio-economic disadvantage, whilst Quintile 5 represent the local government areas with the lowest socio-economic disadvantage.

Appendix 4 Cover letter of questionnaire

27 May 2002

Organisation
Title
Name
Address
Suburb State Postcode

Dear Name

Re: Community Care Services (Aged and Disability) – Improving the Recruitment and Retention of Direct Care Staff

Many organisations in the community care sector have been experiencing difficulty attracting and retaining staff to provide services for the increasing number of frail older people and people with disabilities who are being supported within their communities.

The Victorian Association of Health and Extended Care and the Brotherhood of St Laurence have been funded by the Department of Human Services, through the Home and Community Care Program (HACC), to undertake a study to investigate strategies that may improve both the recruitment and the retention of community care workers. All providers of HACC and HACC-like services are being invited to participate, regardless of their funding source.

The research has three main phases:

- A questionnaire to discover the extent of the problem across the State and to give an indication of the range of initiatives being taken by organisations;
- Interviews with selected organisations to explore successful strategies; and
- A forum and report to publicise the results of the research, including the sharing information about successful strategies.

Enclosed you will find a questionnaire which we are asking you to complete and return. We ask that the completed questionnaire be returned by **Wednesday 12th June 2002**, to the Brotherhood of St Laurence. All information will be treated confidentially, and no identifying information will be used without expressed approval.

We look forward both to your response and to sharing the results of the research with you.

Yours sincerely

Mary Barry
Chief Executive Officer
Victorian Association of Health & Extended Care

Sandra Hills
General Manager of Aged & Community Care
Brotherhood of St Laurence

Appendix 5 Questionnaire

Questionnaire
For Providers of Community Care Services (Aged & Disability)

This questionnaire will provide information about the recruitment and retention of staff who provide community care services. It will also be used to identify organisations that have implemented strategies to address problems in recruitment and/or retention, for the purpose of follow up interviews.

Findings from the research will be shared with the community care sector.

SECTION 1: ORGANISATION PROFILE.
To be completed by all organisations.

SECTION 2: FOR PROVIDERS OF HOME CARE, PERSONAL CARE AND RESPITE CARE.
To be completed only by organisations who employ people to provide these services (volunteers are not to be included). Please restrict your responses to people providing the actual services and not to administrative, assessment or management staff. For simplicity, Home Care, Personal Care and Respite Care staff will occasionally be collectively referred to as Direct-Care staff within this section.

SECTION 3: FOR PROVIDERS OF OTHER COMMUNITY CARE SERVICES – INCLUDING PLANNED ACTIVITY GROUPS, DELIVERED MEALS AND HOME MAINTENANCE.
To be completed only by organisations who employ people to provide these services (volunteers are not to be included). Please restrict your responses to people providing the actual services and not to administrative, assessment or management staff. Planned Activity Groups may also be known by some organisations as Day Programs.

For assistance or for further information please contact:

Philippa Angley: ph. 9483 1377 or email pangley@bsl.org.au
Belinda Newman: ph. 9483 1324 or email bnewman@bsl.org.au

Please return the survey by Wednesday 12 June 2002, either in the reply paid envelope provided, or post to:
Community Care Workforce Project
Brotherhood of St Laurence
67 Brunswick St
Fitzroy 3065

SECTION 1: ORGANISATION PROFILE

1 Contact person:

Name: ______________________________ Position: _____________________________________

Phone: ______________________________ Email: ______________________________________

2 Organisation type:

primarily not-for-profit
local government
primarily private-for-profit

3 DHS Region in which the majority of services are provided:

(Please tick all applicable regions)

Northern Metro
Eastern Metro
Southern Metro
Western Metro
Barwon South Western
Grampians
Loddon Mallee
Hume
Gippsland

4 Type of service/s that you provide:

(Please tick all applicable services)

Home Care
Personal Care
Respite Care (in home & community)
Respite Care (overnight)
Planned Activity/Day Program
Home Maintenance
Delivered Meals
Other (describe) ________

5 Annual turnover of your organisation from community care activities:

Less than $250,000
$250,000-$500,000
$500,000-$1 million
$1 million-$2 million
$2 million-$5 million
$5 million-$10 million
$10 million-$20 million
$20 million plus

6 Number of community care equivalent full-time staff (EFT):

Total: ____________

7 Are community care staff required to provide their own vehicle?

Yes
No

8 If yes, or if staff voluntarily provide their own vehicle, are staff reimbursed/paid for use of own car:

9 Yes (please select method of reimbursement below):

Fixed travel allowance
Per km rate
Other (describe):

No

9 Are community care staff paid for travel time between clients:

Yes
No

If you provide Home Care, Personal Care and/or Respite Care, please complete Section 2. If you provide Planned Activity Groups, Delivered Meals, Home Maintenance or other Community Care services, please complete Section 3.

SECTION 2: FOR PROVIDERS OF HOME CARE, PERSONAL CARE AND RESPITE CARE (In this section referred to as Direct-Care)

To be completed only by organisations who employ people to provide the above services. If you do not, please proceed to Section 3. Please do not include volunteers, or administrative, assessment or management staff.

Part A: Recruitment (Home Care, Personal Care & Respite Care staff only)

10 The direct-care positions you recruit for are:
(Please indicate approximate percentage in each category and ensure the total sum is 100%)

% Full-time:___________ % Part-time:___________ % Casual:_____________

11 Age and gender of direct-care staff (Please estimate number of staff in each category):

	Female	Male
Less than 25 yrs:		
25-34 yrs:		
35-44 yrs:		
45-55 yrs		
over 55 yrs:		
Total		

12 Please indicate the average number of hours worked by part-time and casual direct-care staff per week:

Part-time:_____________(hrs) Casual: ______________(hrs)

13 Does your organisation employ direct-care staff for 'core-hour' positions (guaranteed minimum hours per week)?

Yes No

14 If yes, what percentage of part-time direct-care staff only are employed to work the following amounts of minimum hours?*(Please ensure the total sum is 100%)*

	%		%
Less than 10 hrs per week:		20-24 hrs per week:	
10-14 hrs per week:		25-29 hrs per week	
15-19 hrs per week:		30 or more hrs per week:	

15 If your casual staff are guaranteed a minimum amount of hours per week, what percentage of casual direct-care staff only are employed to work the following amounts of minimum hours?*(Please ensure the total sum is 100%)*

No casual staff are guaranteed minimum hours

	%		%
Less than 10 hrs per week:		20-24 hrs per week:	
10-14 hrs per week:		25-29 hrs per week	
15-19 hrs per week:		30 or more hrs per week:	

16 In the past 12 months has your organisation had difficulty recruiting direct-care staff to provide: *(Please tick all applicable options)*

	Yes	No		Yes	No
Home Care			Respite Care (in-home & community)		
Personal Care			Respite Care (overnight)		

17 If yes, how long has recruitment been a problem?

Less than 12 months More than 24 months
12-24 months

18 If your organisation has had difficulty recruiting direct-care staff, please rank the positions in order of difficulty to fill (1=hardest to fill).

No Difficulty Rank

Home Care
Personal Care
Respite Care (in home & community)
Respite Care (overnight)

19 If your organisation is having difficulty recruiting direct-care staff, why do you think this is so? *(Please list all factors you feel may be significant)*

No Difficulty ______________________________

____

20 Has your organisation implemented strategies aimed at improving the recruitment of direct-care staff ***(this includes strategies aimed at targeting cultural background, gender, out-of-hours staff, etc)***

Yes No

21 If yes, please briefly describe these strategies AND indicate which were successful/unsuccessful.

____

____

22 Does your organisation have a waiting list of clients for home care, personal care & respite care services?

Yes No

23 If yes, please state the one main reason why this waiting list is occurring:

Cannot afford staff due to funding limitations Difficulty recruiting staff
Sudden surge in client numbers Other (please state):

24 Does your organisation require direct-care staff to be qualified (i.e. have training) before they are employed? ***(Please tick your organisation's requirements for each applicable job position)***

Home Care

Only recruit qualified staff
Will recruit unqualified staff and support them in training

Personal Care

Only recruit qualified staff
Will recruit unqualified staff and support them in training

Respite Care (in-home, community, overnight)

Only recruit qualified staff
Will recruit unqualified staff and support them in training

24 What are the minimum qualifications required by your organisation to work in direct-care positions? *(Please state the minimum qualification that you require for each position, or state 'nil' if there is not one required)*

Minimum Qualification:

Home Care:______________________________
Personal Care:______________________________
Respite Care (in-home, community, overnight)______________________________

25 **Does your organisation provide/support/reimburse direct-care staff for ongoing training through:** *(Please tick all applicable options)*

Yes: Details of support

Upskilling existing workforce programs/ traineeships (for existing staff) ___________________

New apprenticeships/ traineeships (for new employees)_________________________________

State govt. funded training places at a registered training organisation (e.g., Certificate III)_____

In-service training not leading to a formal qualification_________________________________

Part B: Retention (Home Care, Personal Care & Respite Care staff only)

26 **Is your organisation concerned about the level of direct-care staff turnover?**

Yes No

27 **If yes, how long has turnover been a problem?**

Less than 12 months
12-24 months
More than 24 months

28 **What is your estimate of direct-care staff turnover in the past 12 months?**

Less than 10%
10-20%
21-30%
31-40%
41-50%
More than 50%

30 **Please provide any further information about direct-care staff turnover (For example, does it vary with position, gender, age, part time, casual etc?).**

____

____

31 **Has your organisation implemented any strategies aimed at minimising direct-care staff turnover?** *(For example, increased wages, non-monetary benefits, etc)*

Yes No

32 **If yes, please describe these strategies AND state whether they have been successful/unsuccessful in reducing turnover. For successful strategies, please indicate the approximate percentage of reduction.**

____

____

33 **How often are supervision and/or staff meetings conducted?**

Weekly
Fortnightly
Monthly
Quarterly
Half-yearly
Yearly
Random/as needed
Not conducted

34 **What opportunities does your organisation provide for career development?** ***(Please describe opportunities provided by your organisation)***

Opportunities include: No opportunities

____

____

35 **Does your organisation offer non-monetary rewards for achievements and/or contributions to direct-care staff?** *(For example, recognition & award programs, opportunities for career development, etc)*

Yes *(Please describe):* ______________________ No

____

36 **Are your direct-care staff involved in the development & review of the care plans allocated to their clients?**

Yes (*Please describe level of involvement*): ______________________ No

____

37 **Please list the reasons you believe direct-care staff are leaving your organisation or the industry, beginning with the most common.**

____

____

38 **Do you know whether direct-care staff who leave your organisation are leaving the industry or moving to another organisation? If yes, please estimate the proportion of staff in each category (%).** (%)

Yes: Leave industry ______________

Leave organisation but remain in industry__________

No

39 **If there were no budget constraints or other restrictions, what would be the one thing you believe could be done to improve recruitment and/or retention of direct-care staff?**

____

____

If you provide Planned Activity Groups, Delivered meals, Home Maintenance or other Community Care services, please complete Section 3.

SECTION 3: FOR PROVIDERS OF OTHER COMMUNITY CARE SERVICES – INCLUDING PLANNED ACTIVITY GROUPS, DELIVERED MEALS AND HOME MAINTENANCE.

To be completed only by organisations who employ people to provide the above services. Please do not include volunteers, or administrative, assessment or management staff.

Part A: Recruitment ('other' Community Care staff only)

10 The direct-care positions you recruit for are:
(Please indicate approximate percentage in each category and ensure the total sum is 100%)

% Full-time:___________ % Part-time:___________ % Casual:_____________

41 Age and gender of 'other' community care staff *(Please estimate number of staff in each category)***:**

	Female	Male
Less than 25 yrs:		
25-34 yrs:		
35-44 yrs:		
45-55 yrs		
over 55 yrs:		
Total		

42 Please indicate the average number of hours worked by part-time and casual 'other' community care staff per week:

Part-time:_____________(hrs) Casual: ______________(hrs)

43 Does your organisation employ 'other' community care staff for 'core-hour' positions (guaranteed minimum hours per week)?

Yes No

44 If yes, what percentage of part-time 'other' community care staff only are employed to work the following amounts of minimum hours?

	%		%
Less than 10 hrs per week:		20-24 hrs per week:	
10-14 hrs per week:		25-29 hrs per week	
15-19 hrs per week:		30 or more hrs per week:	

45 If your casual staff are guaranteed a minimum amount of hours per week, what percentage of casual 'other' community care staff only are employed to work the following amounts of minimum hours?

No casual staff are guaranteed minimum hours

	%		%
Less than 10 hrs per week:		20-24 hrs per week:	
10-14 hrs per week:		25-29 hrs per week	
15-19 hrs per week:		30 or more hrs per week:	

46 Does your organisation provide: *(Please tick all applicable options)*

	Yes	No		Yes	No
Planned Activity Groups			Delivered Meals		
Home Maintenance			Other (please state):____________		

47 **In the past 12 months has your organisation had difficulty recruiting staff to provide:**
(Please tick all applicable options)

	Yes	No		Yes	No
Planned Activity Groups			Delivered Meals		
Home Maintenance			Other (please state):_____________		

48 **If yes, how long has recruitment been a problem?**

Less than 12 months
More than 24 months
12-24 months

49 **If your organisation has had difficulty recruiting staff, please rank the positions in order of difficulty to fill (1=hardest to fill).**

No Difficulty

	Rank
Planned Activity Groups	
Home Maintenance	
Delivered Meals	
Other (please state):_____________	

50 **If your organisation is having difficulty recruiting staff for the above positions, why do you think this is so?** *(Please list all factors you feel may be significant)*

No Difficulty ____
____

51 **Has your organisation implemented strategies aimed at improving the recruitment of 'other' community care staff (this includes strategies aimed at targeting cultural background, gender, out-of-hours staff etc) :**

Yes
No

52 **If yes, please briefly describe these strategies AND indicate which were successful/unsuccessful.**

____
____

53 **Does your organisation have a waiting list of clients for these particular services?**

Yes
No

54 **If yes, please state the one main reason why this waiting list is occurring:**

Cannot afford staff due to funding limitations
Difficulty recruiting staff
Sudden surge in client numbers
Other (please state):

55 **Does your organisation require 'other' community care staff to be qualified (i.e. have training) before they are employed?** ***(Please tick your organisation's requirements for each applicable job position)***

Planned Activity Group
Only recruit qualified staff
Will recruit unqualified staff and support them in training

Home Maintenance
Only recruit qualified staff
Will recruit unqualified staff and support them in training

Delivered meals
Only recruit qualified staff
Will recruit unqualified staff and support them in training

56 What are the minimum qualifications required by your organisation to work in these positions? *(Please state the minimum qualification that you require for each position, or state 'nil' if there is not one required)*

Minimum Qualification:

Planned Activity Group ____________________

Home Maintenance____________________

Delivered meals ____________________

57 Does your organisation provide/support/reimburse staff for ongoing training through:
(Please tick all applicable options)

Yes: Details of support

Upskilling existing workforce programs/ traineeships(for existing staff) __________

New apprenticeships/ traineeships (for new employees)__________

State govt. funded training places at a registered training organisation (e.g., Certificate III)_____

In-service training not leading to a formal qualification__________

<u>Part B: Retention ('other' Community Care staff only)</u>

58 Is your organisation concerned about the level of staff turnover?

Yes No

59 If yes, how long has turnover been a problem?

Less than 12 months
More than 24 months
12-24 months

60 What is your estimate of 'other' community care staff turnover in the past 12 months?

Less than 10%
31-40%
10-20%
41-50%
21-30%
More than 50%

61 Please provide any further information about staff turnover (For example, does it vary with position, gender, age, part time, casual etc?).

____

____

62 Has your organisation implemented any strategies aimed at minimising 'other' community care staff turnover?

Yes No

63 If yes, please describe these strategies AND state whether they have been successful/unsuccessful in reducing turnover. For successful strategies, please indicate the percentage of reduction.

____

____

64 How often are supervision and/or staff meetings conducted?

Weekly
Half-Yearly
Fortnightly
Yearly
Monthly
Random/as needed
Quarterly
Not conducted

65 What opportunities does your organisation provide for career development?

Opportunities include: ______________________ No opportunities
____

66 Does your organisation offer non-monetary rewards for achievements and/or contributions? *(For example, recognition & award programs, opportunities for career development, etc)*

Yes *(Please describe)*: ______________________ No
____

67 Are your 'other' community care staff involved in the development & review of care plans allocated to their clients?

Yes *(Please describe level of involvement)*: ______________________ No
____

68 Please list the reasons you believe 'other' community care staff are leaving your organisation or the industry, beginning with the most common.

____
____

69 Do you know whether staff who leave your organisation are leaving the industry or moving to another organisation? If yes, please estimate the proportion of staff in each category (%).

(%)

Yes: Leave industry _______________

Leave organisation but remain in industry__________

No

70 If there were no budget constraints or other restrictions, what would be the one thing you believe could be done to improve recruitment and/or retention for 'other' community care staff?

____
____

Thank you for your participation.
Please return the survey to the address on the front page by Wednesday 12 June, 2002.

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