The future of education: Workforce and Development Confederations

From 1 April 2001, 24 Workforce and Development Confederations (WDC) replaced the Education and Training Consortia across England. There is still confusion and lack of knowledge about both the consortia and the new WDCs, nowhere more so than in the medical world. The WDCs will be key in the development of all sections of the NHS-trained health- and social-care workforce. What were the consortia and how will the WDCs differ from them? What are the origins of both, and how will the WDCs influence education for health-care staff?

EDUCATION AND TRAINING CONSORTIA

The education contracting originally carried out by regional health authorities was to be moved to local groups of NHS employers, providers and commissioners of care. The groups would also do the necessary workforce planning required to inform the numbers of commissions needed each year in education contracts. These groups became the Education and Training Consortia in 1996.

At the same time, the funds used for this process became one of the three national education and training levies, the non-medical education and training (NMET) levy. Two years later, the consortia gained financial and contractual independence from the NHS Executive's regional offices, which had replaced regional health authorities.

WORKFORCE PLANNING

For consortia, workforce planning was a necessary part of their prime role of commissioning non-medical education in the hospital and community sector. They had little involvement in primary care and none in medical workforce planning. Early in 1999, the Health Select Committee looked at workforce planning in the NHS and concluded that it was fragmented and too complex. The committee recommended a review of workforce planning, which was undertaken and the results published in *A Health Service of all the Talents* (Department of Health, 2000).

The authors of this paper concluded that NHS workforce planning was fragmented, e.g. medical systems were completely separate from everything else. They also concluded that there was a lack of managerial ownership of the workforce and education system, weaknesses in the education systems and that there needed to be greater flexibility of career paths for clinical professionals. The good that had been achieved by the consortia was recognized, together with the need for this to be built upon and extended across all staff. Three key recommendations were the development of WDCs from consortia, the creation in each regional office of a Directorate of Workforce Development, the director of which would have overall responsibility for all workforce and education activity, including that of the postgraduate deans, and the merging of the three education and training levies. All these and most of the other recommendations made in *A Health Service of all the Talents* have been accepted.

CONFEDERATIONS

A WDC is similar to a consortium in that it is a local group of providers and commissioners of health and social care not bounded by the NHS. Neither is a legal entity, with one of the member NHS organizations having to act for the WDC in employing staff and handling finance; for a WDC, the host body will be a health authority. WDCs also include non-NHS members such as social services departments of local authorities as well as the independent and voluntary sectors.

The key differences between consortia and WDCs are that the latter will be involved in medical workforce and education issues as well as in 'supra-employer' human resources issues and will include higher and further education within the WDCs as full strategic partners. WDCs will be concerned with the development of all staff, including the national funding of Individual Learning Accounts (ILAs) and National Vocational Qualifications (NVQs) for staff without a recognized professional qualification and of continuing professional development (CPD) for those with a recognized qualification.

They will have to develop close working relationships with the medical schools, postgraduate deaneries and the human resources directors networks, as well as with non-NHS bodies, such as the Learning and Skills Councils. Forging effective relationships between these groups will not always be easy. There will be tensions about territory, duplication and what is best done at what level. Although WDCs at present only have NMET budgets, by April 2003 they will be responsible for all the educational levies as well as the local application of national ILA, NVQ or CPD funding.

The change in name is not a matter of semantics. Education and Training Consortia were primarily concerned with non-medical professional education and undertook workforce planning as an aid to this. The WDCs will be concerned with the whole health- and social-care workforce, with its appropriate education, training and development as a major subset of this work. This in no way belittles the importance of staff education and development but rather puts it firmly in the context of the future workforce needs of the NHS.

IMPLICATIONS FOR THE FUTURE

What then are the implications for the future of health and social care education? At the lowest level of entry, there should be improved access for people from local communities into the NHS. It is striking that in some inner city areas skills and workforce shortages in the NHS coexist with high levels of local unemployment. Through their members, confederations must be more active in offering local people job opportunities and career development.

The emphasis in the NHS Plan on the development of staff without a professional qualification is being realized through national funding for ILAs to provide greater access to NVQs. Those with potential need to be given educational opportunities to move up the skills ladder within the NHS. There are already initiatives in nursing and the allied health professions to broaden routes of entry and to establish better links between vocational, professional and academic streams of education. WDCs working with their education members will be at the heart of this.

As there is more interest and expertise in the NHS about what it needs to achieve from its staff in terms of education, there will inevitably be a closer examination of what current education is providing. Are staff being prepared to work in the changing world of health and social care? Are they fit for purpose as well as fit for practice? Universities and colleges are going to have to respond to this. The worlds of education and the health service will need to understand each other better, and the WDCs can provide a suitable forum for this debate to prevent polarization of views and defensiveness.

There is much talk of multidisciplinary and interprofessional learning, at present more rhetoric than practice. This must change. Tension and bad relationships between professions contribute to unnecessary stress and a poor working atmosphere (Allen, 2001) — this cannot be conducive to good patient care. At the undergraduate or basic qualification level, WDCs can work with their NHS and education members to use clinical placements more effectively to enable students from different disciplines to work together in a clinical setting and thus to understand each other's roles and perspectives.

Team learning will be increasingly important, and technical advances, such as the use of anaesthetic simulators, through which both technical skills and team dynamics can be assessed, must be supported and developed. This will link clinical governance and risk management more closely with education and development, with CPD being key both to the individual's development and also to the way he/she relates to the organization or team in which he/she works. Having good technical and clinical skills is essential, but no longer enough.

The NHS Plan puts the patient at the centre. This has major implications for education. Health and social care are complex, and navigating them is a major problem for the patient. It is surprising how many staff know very little about the system they work in beyond their immediate clinical area. They can therefore only offer limited help to the patient in coping with the health- and social-care maze. Patients are becoming better informed and more assertive, and some will reasonably want a different type of relationship with those providing care. Current education of health-care staff is not preparing them to meet such challenges. Again, having good clinical skills is not enough.

KEY POINTS

- Current workforce systems are complex and fragmented with too little managerial and organizational ownership and a lack of clarity about roles and responsibilities.
- *A Health Service of all the Talents* recommended the creation of Directors of Workforce Development to oversee all aspects of the system, working through postgraduate deans and the new Workforce and Development Confederations.
- Workforce and Development Confederations would have responsibility for medical and supra-employer human resources issues and an involvement in the development of all staff.
- Confederations are local groupings of those health- and social-care providers within and without the health service who employ NHS-trained staff.
- There is an increased focus on staff without recognized professional qualifications, increased investment in continuing professional development, a focus on multiprofessional and interdisciplinary learning, and links between learning, clinical governance and quality.
- Technology must be used effectively for team-based, distance and e-based learning.

TECHNOLOGY

Educational technology needs to be used more widely. It is not reasonable to expect busy staff to go to where education is being delivered — it must be brought to them. Thus, distance and e-based learning will play a greater role in future health-care education. This needs coordination, skill and investment. Partnerships will be necessary, and the leverage that can be applied through a single education levy can be harnessed through WDCs working with education and other bodies and will be for the good of all staff.

Technology does not get rid of the need for good teachers, but they will need better and different training to enable them to work alongside colleagues from other clinical professions and to use new approaches. Those who teach must have clinical credibility by being involved in clinical practice. WDCs will be uniquely placed to make this happen. These are some of the educational futures that the author anticipates and in which WDCs can play a central role. **HM**

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The views presented in this article are solely those of the author and not necessarily the view of the Department of Health.

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