Have workforce development confederations succeeded?

Workforce development confederations (WDCs) were established in 2001. Three years on – are they making any difference to the quantity, quality or diversity of the workforce that the NHS needs? The evidence is now emerging.

WHY WERE THEY ESTABLISHED?

The most popular myth in answer to this question is that a former Secretary of State asked who was responsible for workforce planning in the NHS. He quickly realized that no-one was responsible. A review was commissioned which resulted in the publication of *A Health Service of All the Talents* (Department of Health (DoH), 2000). This set out a clear structure for addressing workforce issues at both national and local levels, with accountabilities to match. Thus, WDCs were established in April 2001. They now number 28 and match strategic health authority (SHA) boundaries.

WHAT ARE WDCS?

WDCs have a unique organizational form in the NHS's architecture. They are 'member organizations' whereby all the health and social care employers in the area are entitled to be WDC members. Crucially, this includes private and voluntary sector employers too. WDCs are not separate statutory bodies but in legal terms are 'hosted' by one of the member organizations and are supported by the WDC chief executive and his/her team in the WDC office. They are performance managed by the SHAs.

WHAT ARE THEY SUPPOSED TO DO?

WDCs were given the functions summarized in *Table 1*. There are several inherent tensions in their brief. They are substantial resource allocators and performance managers. At the same time they are facilitative and developmental. They are also accountable to several masters – and some of these masters are also their members. Some of these members, such as universities (who are also health-care employers for academic health-care staff), are also in a real and substantial contractual relationship with WDCs.

DEVELOPING AND DELIVERING WORKFORCE STRATEGIES

At long last there is clear responsibility to develop and deliver local workforce strategies that match the service and financial plans. Through WDCs, NHS organizations now have to work together to ensure that there is overall coherence at national level through a variety of mechanisms.

This can only be done within a framework that takes account of the overall demographic and labour market factors facing all sectors of the UK economy. For instance, in February 2004, the number of people employed in the UK reached 28.3 million, an all-time high; at the same time there were still 578 000 registered job vacancies (Office for National Statistics, 2004). The imbalance between retirements and school leavers means there will be 700 000 less people of working age by 2010.

On top of this, the NHS's demand for people is rising sharply over the same period. In round figures, during the years to the end of the 2005–8 spending review period, enough money has been allocated to grow the NHS workforce by the order of 50 000 per year.

This has presented WDCs with a real dilemma. The money allocated to them is overwhelmingly targeted on commissioning preregistration health-care students in 'traditional' professions. Despite the increased number of students, vacancies in the NHS would still increase by about 200 000 over the next few years if WDCs had not developed creative and innovative strategies to grow the workforce.

In fact the workforce of the NHS grew by 58 000 last year and vacancies have not increased. This is a very real and tangible demonstration of the difference that WDCs have already made.

ACHIEVEMENTS

So, what sorts of actions have WDCs included in their strategies to make this

TABLE 1.
The functions of workforce development confederations

Take the lead in visioning the future health-care workforce
Develop and lead an integrated approach to workforce planning for health and social care communities
Have overall responsibility for developing the existing and future workforce
Take the lead in developing a shared approach to human resources policy and practice
Establish robust working relationships with the NHSU, and with NHS, social care and allied learning organizations on behalf of its constituent members
Negotiate, manage and monitor the performance of contracts with education and training providers, and support the modernization of professional preparation, education and training
Have responsibility for practice placements for all students on NHS and Higher Education Funding Council funded health-care training programmes
Actively promote patient, carer and student input into the development and delivery of health-care education and training
Coordinate the strategic management of local NHS learning and education facilities and support capital development plans for those facilities and their revenue consequences
Ensure effective systems and procedures are in place for the financial management and accountability of all funds for which it is responsible
Performance manage workforce issues on the behalf of strategic health authorities

degree of difference. 'More of the same' has been part of the answer. Student numbers have risen sharply since 1999 and this is now feeding through into growing numbers of registered health-care professionals. WDCs have also worked with a whole host of partner organizations on issues such as 'return to practice', cadet schemes, international recruitment, reductions in student attrition rates and improved workforce retention.

Even so, when all these successes are added up they are still unlikely to satisfy the NHS's growing need for people in a tightening labour market. This cries out for a new and more fundamental approach. This is a substantial challenge, but one that WDCs have risen to.

THE NEW VISION

The new vision is one where staff's competencies are recognized in the same way that their professional qualifications are – even when those competencies stray across traditional professional boundaries. National policy initiatives are now enabling this vision, the 'Skills Escalator' (DoH, 2002) and *Agenda for Change* (DoH, 1999) being very good examples. This gives the NHS the opportunity to put in place a flexible, skilled workforce that focuses on the patient and is rewarded appropriately for its knowledge and skill.

This is the key area where WDCs are really starting to make a difference. Collectively at national level they have worked together to produce a paper proposing the establishment of a national framework for assistant practitioners and advanced practitioners. This idea is now being taken up by the DoH and extended into a flexible career framework proposal capable of embracing all staff in the NHS.

ASSISTANT PRACTITIONERS

Given the rapid expansion that is planned for the NHS workforce and the pre-existing difficulties associated with vacancy levels, this development has the potential to fill a large part of the gap. Applications for health-care assistants still outnumber the jobs advertised by as many as 200 to one. Already many health-care assistants are gaining NVQ level 3 and moving on to preregistration programmes. Assistant practitioners take this a step further by introducing a structured, skills-based programme that enables participants to deliver care across the traditional registered/unregistered boundary and across professional boundaries. The patient focus is the paramount driver.

Educationally, trainees will receive a foundation degree on the successful completion of their programmes. Greater Manchester WDC have led the way with this initiative and already have over 600 trainees in place, the first of whom will complete their programmes this summer. Strategically, the intention is that this additional workforce capacity should create space for the further development of other members of clinical teams – particularly with an eye to further developing existing registered practitioners so that they can become advanced practitioners.

ADVANCED PRACTITIONERS

The changing needs of a changing world means that it is imperative that the NHS has the capability to develop some of its practitioners flexibly to meet new challenges. Frequently this will involve them in high level skills and knowledge development that crosses traditional professional boundaries. This trend is being given further momentum by the impossibility of delivering junior doctor medical cover in the traditional way in the face of the European Working Time Directive and *Modernising Medical Careers* (DoH, 2003).

However, by focussing on the knowledge and skills requirements to help all registered practitioners to develop, rather than just the narrower profession-specific focus, it is possible to envisage a more flexible workforce that can work within the 48-hour week without compromising patient safety. There are complex policy and implementation issues to be addressed including relationship to pay systems, the contribution of education and the impact on the regulatory system. Nonetheless, progress is being made. Work is now well underway to develop a national, flexible career framework.

THE YEARS AHEAD

The question is 'Will the momentum be maintained?' This has to be pure conjecture at the moment because barely before WDCs were 2 years old they were being reorganized under the heading of 'integration with SHAs', which had been established 12 months after WDCs. Whether this change will result in a better integration of workforce issues with other issues as intended, or reduce the focus, innovation and broad partnership with all health and social care organizations that WDCs have developed, remains to be seen. HM

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KEY POINTS

- The NHS is facing huge workforce challenges in the next few years.
- The creation of workforce development confederations (WDCs) provides a focus to plan sensibly to meet these challenges.
- WDCs are making a difference – the NHS workforce has expanded rapidly in the last 2 years.
- Workforce modernization has to take place alongside workforce expansion.
- WDCs are now delivering on the workforce modernization agenda.