NHS
Health Education England

**HEE Workforce Planning and Strategic Framework (Framework 15)**

**2015/16 Call for Evidence**

In 2015/16 we are inviting organisations for submissions which address not only immediate workforce planning and education commissioning but which look further ahead and cover wider workforce strategy. For this reason the 2015/16 form covers not only 'conventional' supply and demand concerns, but invites organisations to comment on the wider context of drivers of change and the strategic response. It is organised as follows:

Section 1: Current and future workforce demand and supply

Section 2: Drivers of service demand change

Section 3: Patients and population

Section 4: Models of care

Section 5: Future workforce characteristics

Section 6: Any other evidence

**Submissions should be completed and returned to HEE, using this form, by 30th June 2015 (see below for more information).**

We acknowledge that this is a bigger task than in previous years, and it may entail a higher level of internal deliberation and consultation for your organisation. This is deliberate: we want to learn as much as we can about what organisations are thinking about the long term and the big picture, while simultaneously gathering thinking about the here and now and the more immediate future which will be influenced directly by HEE's commissions in the short term.

**Making your submission**

- We ask that, to maximise input, your submission is completed and returned to HEE by **30th June 2015**
- To submit your evidence please, complete this form. You can provide extracts of reports into the free text boxes below, or submit whole reports. Where an extract is provided, please reference the source.
- In submitting evidence you are invited to take into account the following:

| | |
|---|---|
| HEE's workforce planning guidance | HEE Planning Guidance. Due to the restrictions around the election we have not yet received permission to put the planning guidance on our web site. It has been widely circulated but please contact mandy.knowles1@nhs.net if you do not have a copy. |
| HEE's strategic framework (Framework 15) | http://hee.nhs.uk/2014/06/03/framework-15-health-education-england-strategic-framework-2014-29/ |
| The NHS Five Year Forward view | http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf |

- Once you have completed the form and/or prepared your 'pack', please embed it in an email and return it to hee.workforceplanning1@nhs.net and in the subject heading please use this convention:

**HEE CFE 2015/16 from [your organisation's name in full – avoid acronyms] [Sub version x]**

- Please note, it is not *compulsory* to complete all sections for you to submit a response, but **in order to maximise the value of your submission in informing HEE's 2015/16 education commissions, section 1 should completed and returned by the 30th June 2015.** Later submissions are not wasted as we draw on Caff for Evidence returns throughout the year for a variety of purposes.

**Your contact details**

Before completing the form below please submit your contact details here:

| | |
|---|---|
| Name | Dr Mark Zuckerman |
| Job title/role in organisation | Chair of the Specialty Advisory Committee in Virology |
| Organisation (in full please) | Royal College of Pathologists |
| Contact email | mark.zuckerman@kcl.ac.uk / Fiona.addiscott@rcpath.org |
| Contact number | 020 3299 9000 x 36978 / 020 7451 6726 |
| Submission version (if you resubmit at any point) | 1 |
| Date | 30/06/2015 |

**Data Protection and Freedom of Information**

The information you send us may be made available to wider partners, referred to in future published workforce returns or other reports and may be stored on our internal evidence database.

Any information contained in your response may be subject to publication or disclosure if requested under the Freedom of Information Act 2000. By providing personal information for this review it is understood that you consent to its disclosure and publication. If this is not the case, you should limit any personal information provided or remove it completely.

**Section 1 – Current and future workforce demand and supply**

Use this section to input evidence into the forecasting of future workforce numbers. Report here your perspectives on either;

i) the high level indicators; supply, demand, and any forecast under / over supply
or if available
ii) the more granular components of these three components e.g. retirement rates, output from education relative to attrition

**1.1 Summary forecasts**

- Forecast Workforce Demand
- Forecast Workforce Supply and Turnover
- Forecast Under / Over Supply

Drivers of workforce demand include:

Increased demands for virological clinical opinion concerning :

- the management of patients with viral infections with the advent of more sensitive, specific and rapid tests and new antiviral drugs
- tests for antiviral drug resistance particularly HIV, hepatitis B and C, cytomegalovirus (CMV), herpes simplex virus infections and influenza
- increasing numbers of both recipients of and types of organ transplantation, increasing numbers of patients treated with immunosuppressive drugs
- novel viruses often with potential for widespread disease include MERS-CoV, avian influenza A H7N9 virus, Ebola virus, dengue virus and chikungunya virus infections from a diagnostic and infection control perspective

Workforce supply and turnover

Together with laboratory centralisations/mergers, joint ventures with private companies have changed the virological landscape in the last few years with varied results. This has not had an immediate effect on medical workforce numbers but is likely to do so in the future.

Currently, there are 65 whole time and 7 part-time medical consultant virologists and 10 consultant clinical scientists working in the United Kingdom (Clinical Virology Network data). There are two vacant consultant medical virologist posts. There has been 1 retirement in the last 6 months and 1 vacant post has been filled.

Under/over supply:

The move to broader infection training where virologists, microbiologists and infectious diseases physicians will all receive core medical training and laboratory and clinical infection training will lead to specialist virologists with more clinical input and direct patient care in an infection team. Such Infection trained doctors may be expected to participate in acute medicine rotas which may alter working practice and reduce time spent in laboratories.

Developments in higher specialist training for clinical scientists under Modernising Scientific Careers will see more of these individuals holding senior laboratory posts

**1.2 Detailed / Component forecasts**

**Forecast Workforce Demand**

- Service Demand drivers
- Change in use of temporary staff
- Addressing historic vacancies
- Skill Mix / New Roles
- Workforce Productivity

Service Demand Drivers: As detailed in part 1.1

Addressing historic vacancies: This has not been an issue, more dependent on whether those posts will be reconfigured as the new combined infection training programme has greater emphasis on core medical training with MRCP and increased training in infectious diseases. Trainees will decide whether they wish to specialise in virology in the latter part of the programme

Skill Mix/New Roles

- Increased clinical involvement of doctors trained under the combined infection training scheme (beginning August 2015)
- Increased requirement for training clinical scientists
- Increase in 7 day working in virology (may lead to need for increased numbers required)

**1.3 Forecast Supply from HEE commissioned education**

- Assumed training levels
- Under recruitment
- Attrition
- Employment on completion of training

Assumed training levels

There are around 30 trainees in Virology in the UK including trainees training jointly in Virology and Infectious Diseases (Clinical Virology Network (CVN) data) and this number is likely to remain essentially unchanged. RCPath records identify 31 trainees of whom 17 are single specialty Virology trainees and 14 dual Virology/Infectious Diseases trainees. Many Virology training posts have in fact been converted to joint training posts as these are more attractive to candidates and to potential employers and are more in line with the future direction of the Infection specialties such as Virology ie more clinically focused

Attrition: There is no evidence of disestablishment of virology posts at the present time

Employment on Completion of Training: Employment prospects seem reasonable overall. There is not a lot of competition for posts compared with a decade ago

**1.4 Forecast Supply – Other Supply and Turnover**

- From other education supply
- To/from the devolved administrations
- To/from private and LA health and social care employers
- To/from the international labour market
- To/from other sectors / career breaks and 'return to practice'
- To/from other professions (e.g. to HV or to management)
- Increased / decreased participation rates (more or less part time working)
- Retirement

Other Supply and Turnover
Currently, there are 65 whole time and 7 part-time medical consultant virologists and 10 consultant clinical scientists working in the United Kingdom (Clinical Virology Network data). There are two vacant consultant medical virologist posts. There has been 1 retirement in the last 6 months and 1 vacant post has been filled

There are poor data on retirement intentions

There is no introduction of consultants in virology coming to the NHS from the private sector and there are limited opportunities for virologists to work in the private sector in substantive posts

As regards the international labour market, the decision was taken in 2012 to remove Microbiology and Virology from the Home Office Shortage Occupation List.

Despite almost automatic recognition in the UK of a Specialty Certification obtained in another EU state, the specialty of Medical Microbiology and Virology is not recognised in all EU states, limiting the numbers of specialists who may wish to move to the UK. Furthermore, there is increasing demand for microbiologists in certain EU states, attracting some UK specialists to move overseas. However, the pattern of training in many EU countries is sufficiently different from that in the UK that they are unlikely to fulfil the Royal College of Pathologists model Person Specification, limiting the likelihood of continental European trained specialists from being appointed to UK posts

Internationally, there is some limited interest from EU doctors trained in Microbiology and/or Virology

**Section 2 - Drivers of service demand change**

| Timescale/time horizon | | |
|---|---|---|
| **Framework 15 message:** | **Longer term – to 15 years** | **Shorter term to 5 years** |
| | Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15?<br>Please detail your evidence about the **longer term** | Please detail your evidence about the **shorter term**, specifically: |
| We believe that our population is **getting older**, and that for our workforce, preferences for a change in patterns in working is increasing. | Yes. There is a move to 24/7 working patterns | It is a question of need. Consideration must be given to the waiting time for results that are not required urgently i.e. same day. From an infection control perspective, same day chlamydia, gonorrhoea, respiratory virus testing, as examples, would help reduce transmission. However, a discussion about what the population feels about waiting times for test results that are not urgent may reveal that 24/7 access is not necessary |
| The influence of technology is growing in healthcare and beyond, with staff and patients using it to **increase personalisation and control** in their life. What will be its possible impact in healthcare in the years ahead? The influence of **genomics and research** will also play a vital part. | Point of care tests and 24/7 working will lead to results being available more rapidly | Point of care tests and 24/7 working will lead to results being available more rapidly. Staff in health centres will need training and issues around quality control and clinical governance will need to be understood |
| Wider factors are creating global pressures to **constrain the cost** of publicly funded healthcare, with the wider concept of wellness increasingly taking root which people will expect health service to respond to. | It will be interesting to see this will be costed as the tests produced by commercial companies will always be more expensive than in-house tests. However, work needs to be carried out to understand the benefits of these tests in terms of management of patients and costs to the service before widespread introduction | It will be interesting to see this will be costed as the tests produced by commercial companies will always be more expensive than in-house tests. However, work needs to be carried out to understand the benefits of these tests in terms of management of patients and costs to the service before widespread introduction |
| Patients are going to want **high quality services anytime, any place, anywhere**, with a more equal (and challenging ) relationship with staff, but one still based on care and a better work life balance. | It will be interesting to see this will be costed as the tests produced by commercial companies will always be more expensive than in-house tests. However, work needs to be carried out to understand the benefits of these tests in terms of management of patients and costs to the service before widespread introduction | It will be interesting to see this will be costed as the tests produced by commercial companies will always be more expensive than in-house tests. However, work needs to be carried out to understand the benefits of these tests in terms of management of patients and costs to the service before widespread introduction |

**Section 3 – Patients and population**

| Timescale/time horizon | | |
|---|---|---|
| **Framework 15 message:** | **Longer term – to 15 years** | **Shorter term to 5 years** |
| | Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15?<br>Please detail your evidence about the **longer term** | Please detail your evidence about the **shorter term**, specifically: |
| With people living longer with more people living with **multiple and complex conditions** (and with our workforce being currently predominantly trained to treat distinct and different disease in isolation after a health crisis has occurred). How can we educate/train the workforce to support the prevention of ill health and, where ill health occurs, support staff to work across organisational boundaries to support high quality care for people with a range of health needs (across physical, mental health and social care)? | This is being addressed with combined infection training with an emphasis on core medical training, infectious disease and understanding and gaining experience of the laboratory tests. Longer term, the combined approach will provide a more global approach to healthcare | All will increase |
| Our patients and population are likely to be at different stages of being **informed, active and engaged** in their own healthcare (including using for example, data and online records), with our challenge being to support the development of a workforce which can support high quality care for all patients. | No | All will increase |

| Timescale/time horizon | | |
|---|---|---|
| **Framework 15 message:** | **Longer term – to 15 years** | **Shorter term to 5 years** |
| | Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15?<br>Please detail your evidence about the **longer term** | Please detail your evidence about the **shorter term**, specifically: |
| Patients will increasingly be members of a **community of health,** with the number of carers projected to rise significantly in the years ahead**.** Five Year Forward View highlights four ways in which we can engage with communities and citizens in new ways, to build on the energy and compassion that exists in communities across England, namely:<br>• better support for carers<br>• creating new options for health-related volunteering<br>• designing easier ways for voluntary organisations to work alongside the NHS<br>• using the role of the NHS as an employer to achieve wider health goals | Not applicable to Virology | Not applicable to Virology |
| Developing **substantial community provision** to bring about a substantial reduction in the numbers of people with learning disabilities placed inappropriately in institutional care is a central part of Sir Stephen Bubb's report in 2014 ('*Winterbourne View – time for change* ). | Not applicable to Virology | Not applicable to Virology |
| **Parity of esteem for Mental Health** will be supported through delivering improvements in areas such as integration, waiting and access targets and in the area of psychiatry liaison | Not applicable to Virology | Not applicable to Virology |

| Timescale/time horizon | | |
|---|---|---|
| **Framework 15 message:** | **Longer term – to 15 years** | **Shorter term to 5 years** |
| | Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15?<br>Please detail your evidence about the **longer term** | Please detail your evidence about the **shorter term**, specifically: |
| Five year forward view draws attention to the NHS being committed to making **substantial progress** in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds. | Equality and diversity and non-discriminatory ladders of opportunity are integral to our workplaces and to RCPath | Equality and diversity and non-discriminatory ladders of opportunity are integral to our workplaces and to RCPath |

**Section 4 – Models of care**

| Timescale/time horizon | | |
|---|---|---|
| **Framework 15 message:** | **Longer term – to 15 years** | **Shorter term to 5 years** |
| | Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15?<br>Please detail your evidence about the **longer term** | Please detail your evidence about the **shorter term**, specifically: |
| **Five Year forward View** outlines a number of possible future service models including<br>• multispecialty community providers (MCPs), which may include a number of variants<br>• integrated primary and acute care systems (PACS)<br>• additional approaches to creating viable smaller hospitals<br>• models of enhanced health in care homes<br><br>The **expertise to support** the piloting and introduction of these models need to be considered. Existing NHS services and areas of the healthcare workforce may work with others in new and different ways (e.g. community pharmacy). | Together with laboratory centralisations/mergers, joint ventures with private companies have changed the virological landscape in the last few years with varied results.<br>MCPs and PACS are good examples of better access but everything needs to be unified, standardised and implemented once the systems having been tested in different regions | Together with laboratory centralisations/mergers, joint ventures with private companies have changed the virological landscape in the last few years with varied results.<br>MCPs and PACS are good examples of better access but everything needs to be unified, standardised and implemented once the systems having been tested in different regions<br>Point of care tests and 24/7 working will lead to results being available more rapidly. Staff in health centres will need training and issues around quality control and clinical governance will need to be understood |
| Services are likely to become **increasingly integrated** in the future, enhanced through policies such as the Devolution of Local health and social care budgets, the integrated care pilots and integrated personal commissioning. Partnerships will become increasingly important, including with partners beyond NHS and social care. | Together with laboratory centralisations/mergers, joint ventures with private companies have changed the virological landscape in the last few years with varied results.<br>MCPs and PACS are good examples of better access but everything needs to be unified, standardised and implemented once the systems having been tested in different regions | MCPs and PACS are good examples of better access but everything needs to be unified, standardised and implemented once the systems having been tested in different regions<br><br>Point of care tests and 24/7 working will lead to results being available more rapidly. Staff in health centres will need training and issues around quality control and clinical governance will need to be understood |

| Timescale/time horizon | | |
|---|---|---|
| **Framework 15 message:** | **Longer term – to 15 years** | **Shorter term to 5 years** |
| | Are you aware of any new evidence which impacts in the light of this - do you think there is the need for a different message for Framework 15?<br>Please detail your evidence about the **longer term** | Please detail your evidence about the **shorter term**, specifically: |
| We may increasingly see **centres of specialisation** in some specialties in some areas. | Virology is at a crossroads. There are already bigger centres with experienced staff carrying out in-house and commercially available specialised tests as well as high volume assays and smaller centres running commercially available specialised tests with less experienced staff<br>Regional virology centres will integrate fully with microbiology and genomics | It is already happening but needs to be thought though carefully and implemented in a unified fashion. |
| We will see the ongoing development of services in the area of **urgent and emergency care** | Yes and point of care diagnostics, rapid genome analysis and 24/7 working will be in place | It is already happening but needs to be thought though carefully and implemented in a unified fashion. |
| Five Year Forward View highlights new developments such as the **evidence based diabetes prevention service** and **encouraging new capacity in under doctored areas.** | Not applicable to Virology | Not applicable to Virology |

**Section 5 – Future workforce characteristics**

| Timescale/time horizon | | |
|---|---|---|
| **Framework 15 message:** | **Longer term – to 15 years** | **Shorter term to 5 years** |
| **Below are the 5 future workforce characteristics set out in Framework 15** | In your evidence please highlight any or all of the following:<br>- Are these workforce characteristics still valid?<br>- Any evidence you are aware of work which is underway and which contributes to the achievement of the workforce characteristics<br>- Any gaps you are aware of<br>Please detail your evidence about the **longer term** | Please detail your evidence about the **shorter term** education and training needs required for the current workforce to meet these characteristics: |
| The workforce will include the informal support that helps people prevent ill health and manage their own care as appropriate. | Not applicable to Virology | Not applicable to Virology |
| Have the skills, values and behaviours required to provide co-productive and traditional models of care as appropriate. | Not applicable to Virology | Not applicable to Virology |
| Have adaptable skills responsive to evidence and innovation to enable 'whole person' care, with specialisation driven by patient rather than professional needs. | Not applicable to Virology | Not applicable to Virology |
| Have the skills, values, behaviours and support to provide safe, high quality care wherever and whenever the patient is, at all times and in all settings. | Not applicable to Virology | Not applicable to Virology |
| Deliver the NHS Constitution: be able to bring the highest levels of knowledge and skill at times of basic human need when care and compassion are what matters most. | Not applicable to Virology | Not applicable to Virology |

**Section 6 – Any other evidence not included elsewhere**

Virology remains a growing and increasingly clinically relevant specialty with rapid progress in diagnostics and treatment as well as of continued relevance to public health and infection control.

**Figure 1**
Consultant total by region

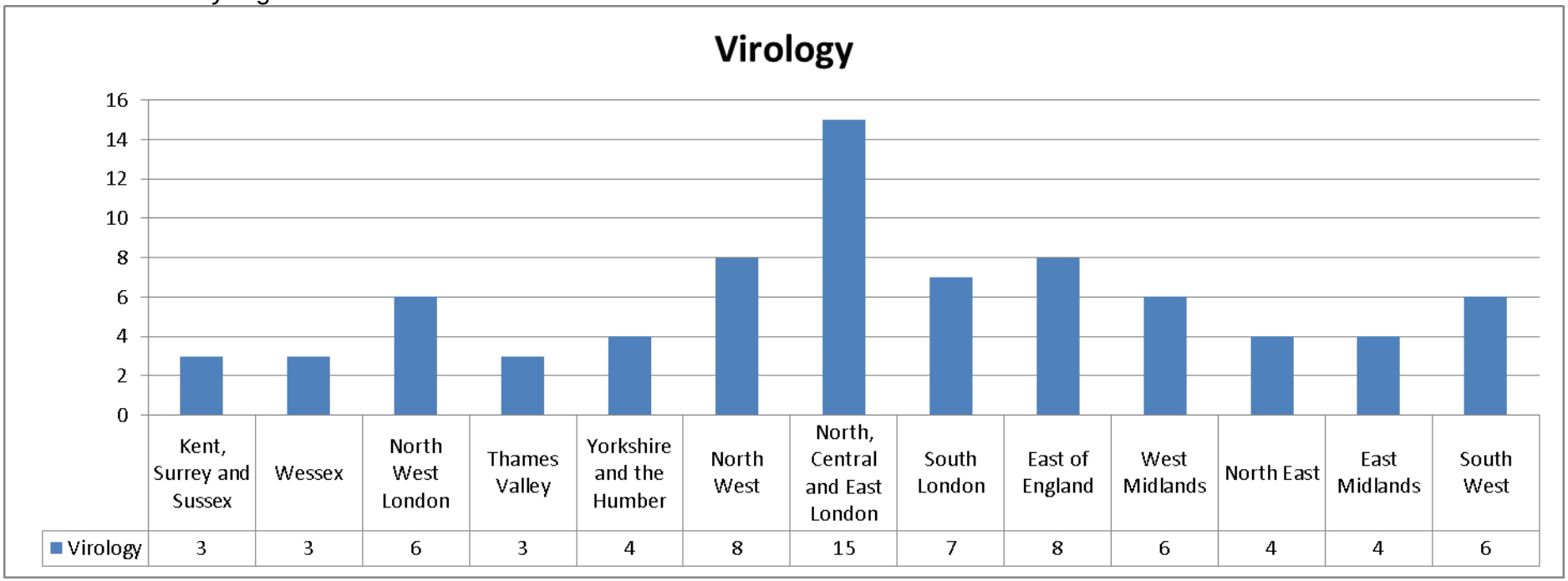

**Figure 2** Consultant total by age

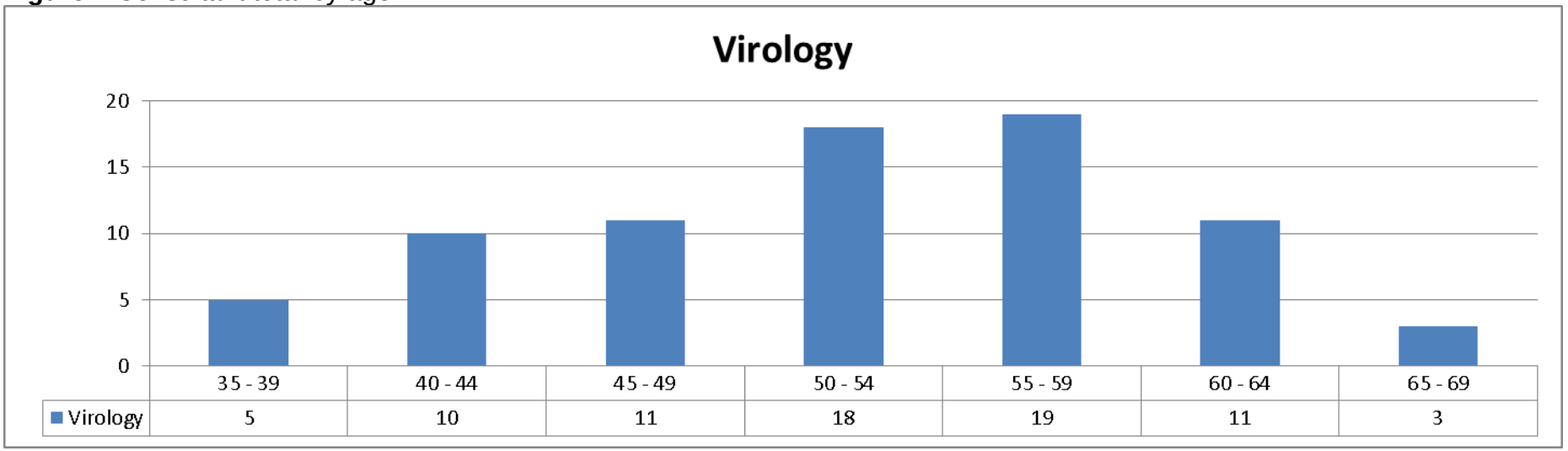


**Figure 3** Consultant total by gender

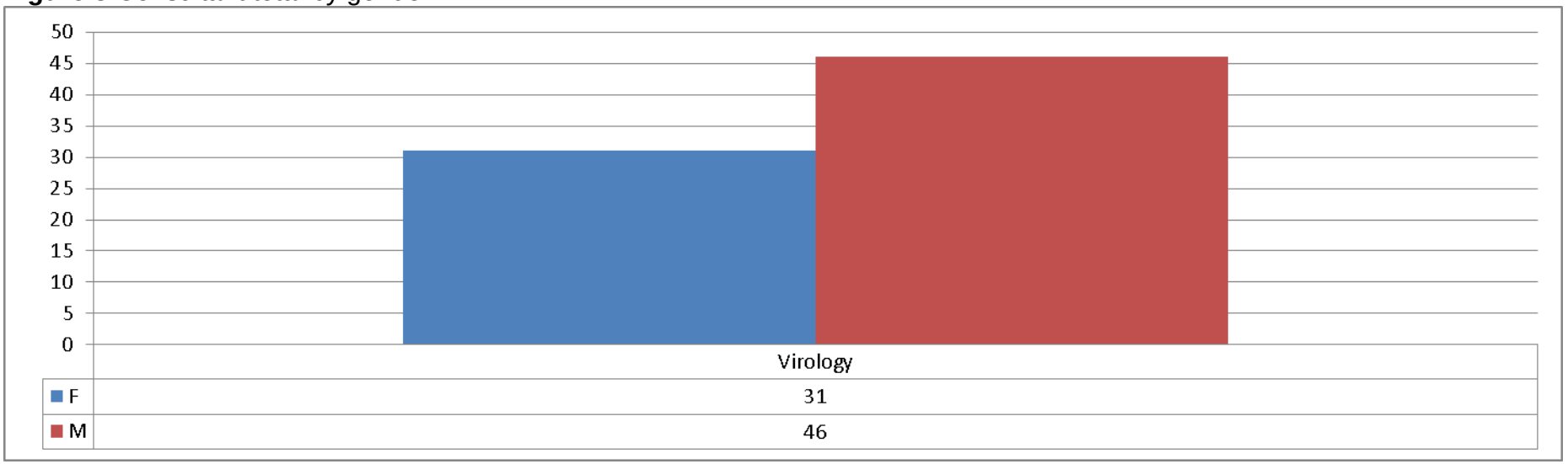

**Figure 4**
Consultant Full/part time