The current use and future service requirements of Clinical Fellows in the RNOH

Author: Rob Hurd, Chief Executive
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To be submitted to:
Medical Management and Clinical Engagement Steering Group
Executive Team
Service Transformation Committee

Version number: Draft version 2

Location of report:
1. **Purpose of report**

1.1. The purpose of this paper is to set out how clinical fellows are deployed at the RNOH, the benefits they bring to the organisation and the concerns that have been expressed in view of their increasing usage.

1.2. It outlines where they are currently employed in the organisation, their job descriptions and job plans and makes recommendations in terms of their future role at RNOH.

2. **Background**

2.1. The last review of fellows at the RNOH was carried out in November 2009. At that time the RNOH was employing 15 Fellows (excluding “Night Fellows” – see below). Of these 5 were non-recurrently funded (2 by the Royal College of Surgeons and 3 from industry). The review concluded with a decision to permanently fund these 5 posts from NHS clinical budgets, given the contribution made by these staff to clinical activity over and above their primary training role. This funding has been in place since April 2010. The total number of fellows at RNOH as at February 2012 has now increased to 20. Two of these are funded by non-NHS sources and a further 3 have not yet been formally permanently established in the budget but are in the process of being approved via an internal business case process.

2.2. The Trust is also in the process of reviewing its alleged poor PROMs ratings to establish the extent to which this is driven by a lack of reflection of casemix complexity or whether there is any evidence of PROMs rating linking to seniority of medical staff undertaking the procedure.

2.3. **Definition of the Clinical Fellow Role**

A clinical fellow is a medical doctor seeking postgraduate training in a specialty, or subspecialty discipline. Clinical Fellows may be engaged in research and teaching and may provide clinical service as part of their training program; however, the primary goal of the clinical fellowship program is for the trainee to gain knowledge and skills in a particular discipline. It is not primarily to provide service within a department. The term “fellow” has been applied to medical staff ranging from a more junior level (ST1/2 level) e.g. RNOH “Night Fellows” to post-certificate of completion of training (CCT) Fellowships.

2.4. In recent years post-certificate of completion of training (CCT) Fellowships have been extensively advertised and promoted by professional bodies as providing further subspecialist experience and service development opportunities, but criticized by other bodies as creating sub-consultant service posts that lack a clear defined educational role in a non-training post.

2.5. As a result of shortened training time, the European Working Time Directive and other medical training factors, it is becoming more difficult to ensure that the higher specialist training programme allows sufficient time for doctors to acquire the relevant subspecialist and generic management skills, therefore, a position of fellow either pre or post CCT can be of value to individuals. Although, the aim of a Fellowship is primarily to conduct research or to learn new skills or techniques, they can add value to the NHS by supporting service delivery.
2.6. This paper does not consider “fellows” at a more junior level (Senior House Officer/ST 1/2 level) working at the RNOH. However, it should be noted by way of background that these junior “fellows” have also become a fundamental part of the RNOH’s approach to meeting the EWTD hour limits of 2004 (56 hour limit) and 2009 (48 hour limit). To preserve the ‘firm’ structure and maintain the excellent training and teaching that is experienced by our junior medial staff (as evidenced in the PMETB surveys), the Trust has not wanted to adopt a full shift system or implement ‘Hospital at Night’ and therefore the Fellows have adopted a night rota to cover the hospital at night. This approach has proved successful because the ‘Night Fellows’ are experienced Senior House Officers and as such have strong experience of the RNOH. The use of junior fellows in this way provides a safe and cost effective service at night and ensures the Trust is legally compliant in relation to the EWTD.

2.7. Benefits - Arguments in favour of Clinical Fellows

2.7.1. The recruitment of a Clinical Fellow provides additional capacity at a lower cost than a consultant, often with more time designated as direct care. With the impact of EWTD resulting in less time for doctors in training to gain ‘hands on experience’ the Fellow can acquire valuable experience, working independently but not being ‘out of their depth’, thereby supporting their development into a consultant.

2.7.2. Some consultants have stated that they benefit from being able to delegate more routine work to the Fellow allowing them to focus on complex work. The Consultant will still oversee and supervise the Fellow and take responsibility for their work. Some consultants feel that Fellows enhance productivity through providing more capacity flexibility in managing variable case mix complexity.

2.7.3. Fellows do not arrive with the same referral base and waiting list pressures as established consultants and therefore they can assist with demand pressures.

2.7.4. Fellows potentially provide a more flexible workforce through supporting, for example through pilots of, new and different ways of working and medical support at a more cost effective level than a full consultant appointment.

Examples of Feedback provide by Consultants/Clinical Leads

Consultant Spinal Surgeon on benefits of Fellows

“1. To help us deal with the clinical workload: My own firm has had less than 3 career registrars in the last 5 years: the rest have been locums, and have been very junior. They have therefore been unable to make any decisions or perform any operations, placing an intolerable burden on the Consultant in a busy firm

2. To enable us to increase the patient throughput, by using any additional capacity in theatres

3. To start work on ‘rapid throughput’ pathways for patients with relatively straightforward surgical procedures. Hospital stays are way too long at the RNOH.

4. To provide an opportunity for peri- CCT training in spinal deformity and degenerative conditions that is perhaps unique in the UK

5. To work on specific research projects - eg the RCT we are starting on muscle damage after spinal surgery.
In the longer term, we will incorporate the position into the Spine Society of Europe training Diploma, which may be able to provide funding for such Fellowship[s]. To this end I am applying for the position of Liaison Officer for Spinal Education between the SSE and BASS [British Association of Spine Surgeons]"

**Consultant in Hip & Knee Joint Reconstruction**

“I think it is important that Fellows are not used instead of a Consultant. The Fellows should be regarded as a training post, but part of the training does involve operating on patients independently i.e. without direct Consultant involvement but still being supervised by the Consultant”

### 2.8. Concerns – Arguments against

2.8.1. There have been concerns raised that from a patient and quality of care perspective the use of fellows deviates the RNOH from maintaining a Consultant provided service. Although requiring less supervision than an SpR the resources required of a consultant to support a Fellow may divert time away from a consultant’s work. The resources required to be in place for a Fellow may be different to that of a more experienced consultant both in theatres and clinics.

2.8.2. Given the nature of the role a fellow appointment is likely to be short term relative to consultant appointments because an individual may leave their position if appointed to a consultant position. This can lead to a lack of continuity and higher turnover than the equivalent consultant provided service.

2.8.3. The RNOH does not currently record activity, workload figures separately for Fellows as they sit within the Consultant “firm’s” figures. Therefore the relative merits of additional productivity arising from higher Direct Clinical Care job plans and flexibility vs. reduced productivity through a non-consultant provided service are currently impossible to establish objectively.
3. **RNOH Fellows Employed as at 31st January 2012**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Specialty</th>
<th>Name</th>
<th>Job Title</th>
<th>Consultant</th>
<th>Job Plan Sessions</th>
<th>Funding</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Spinal Surgery</td>
<td>Jonathan Bull</td>
<td>Depuy Fellow</td>
<td>Adrian Casey Kia Rezajooi</td>
<td>4 Theatre 1 Research 1 Clinic 1 MDT/Clinic 2 MDT/Theatre 1 Admin/Research</td>
<td>Depuy</td>
<td>9/8/11</td>
<td>8/8/12</td>
</tr>
<tr>
<td>2</td>
<td>Spinal Surgery</td>
<td>Nanjundappa Harshavardhana</td>
<td>Fellowship in Spinal Trauma Surgery</td>
<td>Hilali Nordeen</td>
<td>5 Theatre 2 Clinics 1 Ward round/theatre 1 MDT Meeting/Theatre 1 Admin/Research</td>
<td>NHS Clinical*</td>
<td>11/7/11</td>
<td>2/8/12</td>
</tr>
<tr>
<td>4</td>
<td>Upper Limb</td>
<td>Ofir Uri</td>
<td>Clinical Fellow in Shoulder and Elbow Reconstruction</td>
<td>Simon Lambert</td>
<td>6 Theatre 3 Clinics 1 Research/Admin</td>
<td>NHS Clinical</td>
<td>1/5/12</td>
<td>30/4/13</td>
</tr>
<tr>
<td>5</td>
<td>Paediatric Surgery</td>
<td>Leanora Mills</td>
<td>Fellow in Paediatric Orthopaedic Surgery (SpR Level)</td>
<td>Deborah Eastwood</td>
<td>[6 Months GOSH/ 6 Months RNOH] 3 Theatre 2 Clinics 5 Research/Teaching/Ward</td>
<td>NHS Clinical</td>
<td>1/1/12</td>
<td>30/6/12</td>
</tr>
<tr>
<td>Ref</td>
<td>Specialty</td>
<td>Name</td>
<td>Job Title</td>
<td>Consultant</td>
<td>Job Plan Sessions</td>
<td>Funding</td>
<td>Start Date</td>
<td>End Date</td>
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<tr>
<td>6</td>
<td>Paediatric</td>
<td>Paul Whittingham-Jones</td>
<td>Clinical Fellow - Young Adult Hip</td>
<td>Aresh Hashemi-Nejad</td>
<td>3 Theatre 2 Clinics 2 Ward rounds 2 Research/Clinic Cover 1 Research/Admin</td>
<td>NHS Clinical</td>
<td>5/10/11</td>
<td>30/6/12</td>
</tr>
<tr>
<td>7</td>
<td>Foot &amp; Ankle</td>
<td>James Murray-Brown</td>
<td>Foot &amp; Ankle Fellow</td>
<td>Dishan Singh</td>
<td>TBC</td>
<td>NHS Clinical</td>
<td>1/1/12</td>
<td>30/6/12</td>
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<tr>
<td>8</td>
<td>Imaging</td>
<td>Hassan Douis</td>
<td>Clinical Fellow in Musculoskeletal Radiology</td>
<td>Supervised by all Radiologists</td>
<td>7 Clinical (4 interventional/3 Reporting) 3 Research/Admin</td>
<td>NHS Clinical</td>
<td>3/10/11</td>
<td>2/4/12</td>
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<tr>
<td>9</td>
<td>Imaging</td>
<td>Himal Gajjar</td>
<td>Clinical Fellow in Musculoskeletal Radiology</td>
<td>Supervised by all Radiologists</td>
<td>7 Clinical (4 interventional/3 Reporting) 3 Research/Admin</td>
<td>NHS Clinical</td>
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<td>9/4/12</td>
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<tr>
<td>10</td>
<td>Imaging</td>
<td>Vacant</td>
<td>Clinical Fellow in Musculoskeletal Radiology</td>
<td>Supervised by all Radiologists</td>
<td>7 Clinical (4 interventional/3 Reporting) 3 Research/Admin</td>
<td>NHS Clinical</td>
<td>31/10/11</td>
<td>30/4/12</td>
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<tr>
<td>11</td>
<td>Histopathology</td>
<td>Vacant (Non-Recurrent funded post)</td>
<td>Honorary Clinical Fellowship in Histopathology</td>
<td>Adrienne Flanagan</td>
<td>TBC</td>
<td>J.U.S.T</td>
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<tr>
<td>12</td>
<td>JRU/Sarcoma</td>
<td>Jeeshan Rahman</td>
<td>JRU Research Fellow</td>
<td>John Skinner</td>
<td>4 Theatre 5 Clinics 1 MDT / research</td>
<td>NHS Clinical</td>
<td>26/10/11</td>
<td>25/10/12</td>
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<tr>
<td>13</td>
<td>JRU/Sarcoma</td>
<td>Peter Darcy</td>
<td>Clinical Fellow in Lower Limb Reconstruction : Orthopaedic/Arthroplasty/Orthopaedic Oncology Clinical Fellow</td>
<td>John Skinner</td>
<td>2 Theatres 3 Clinics 4 Clinical Admin (inc notes review) 1 MDT</td>
<td>NHS Clinical</td>
<td>31/10/11</td>
<td>30/4/12</td>
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<tr>
<td>14</td>
<td>JRU/Sarcoma</td>
<td>Elizabeth Gillot</td>
<td>West Herts/RNOH Research Fellow</td>
<td>Tim Briggs</td>
<td>TBC</td>
<td>NHS Clinical</td>
<td>7/10/11</td>
<td>4/10/12</td>
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<tr>
<td>Ref</td>
<td>Specialty</td>
<td>Name</td>
<td>Job Title</td>
<td>Consultant</td>
<td>Job Plan Sessions</td>
<td>Funding (items marked *not in yet in budget)</td>
<td>Start Date</td>
<td>End Date</td>
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<tr>
<td>15</td>
<td>JRU/Sarcoma</td>
<td>Demos Neophytou</td>
<td>West Herts/RNOH Research Fellow</td>
<td>Tim Briggs</td>
<td>TBC</td>
<td>NHS Clinical</td>
<td>10/10/11</td>
<td>9/4/12</td>
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<td>16</td>
<td>JRU/Sarcoma</td>
<td>Stephen Ng Man Sun</td>
<td>West Herts/RNOH Research Fellow</td>
<td>Tim Briggs</td>
<td>TBC</td>
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<td>5/10/11</td>
<td>4/10/12</td>
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<tr>
<td>17</td>
<td>JRU/Sarcoma</td>
<td>Vijai Ranawat</td>
<td>Arthroplasty Fellow – Joint with St. Albans</td>
<td>Richard Carrington</td>
<td>7 Theatre 1 Clinic 1 Ward round/admin 1 Research</td>
<td>NHS Clinical</td>
<td>15/8/11</td>
<td>3/4/12</td>
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<td>18</td>
<td>JRU/Sarcoma</td>
<td>Sebastian Dawson-Bowling</td>
<td>Arthroplasty Fellow – Joint with Stoke Mandeville</td>
<td>Richard Carrington</td>
<td>7 Theatre 1 Clinic 1 Ward round/admin 1 Research</td>
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<td>1/2/12</td>
<td>31/7/12</td>
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<td>19</td>
<td>Chronic Pain</td>
<td>Amod Manocha</td>
<td>Clinical Fellow in Pain Management</td>
<td>Jonathan Berman</td>
<td>TBC</td>
<td>NHS Clinical</td>
<td>1/2/12</td>
<td>31/7/12</td>
</tr>
<tr>
<td>20</td>
<td>Foot &amp; Ankle</td>
<td>Zaidi</td>
<td>Foot &amp; Ankle Fellow</td>
<td>Dishan Singh</td>
<td>TBC</td>
<td>Mat Ortho</td>
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4. Conclusions

"Feedback from Prof Tim Briggs, Joint Medical Director and Clinical Lead for Sarcoma Unit"

Many thanks for sharing this draft with all of us. In response I think there are a number of issues that need to be understood further.

1. As stated in the paper, fellows vary enormously in seniority. Junior fellows are there mainly for research and certainly on our service, gain their clinical experience in trauma at Watford where we have an excellent link with the orthopaedic department headed up by Neil Davies. These jobs are extremely popular because they not only provide a research environment but a clinical skills environment for trainees wanting to become orthopaedic surgeons and gaining access to specialty training. We sometimes use them at Stanmore to help with clinics. They do not do independent operating.

2. We then have 2-3 senior fellows. As trainees become more senior the amount of time that is spent on their educational content reduces and the amount they can spend on service increases. Typically for a Post CCT fellow I would expect 85% of their work to be service and 15% to be training. Their training needs are very different and we need to emphasise the vision of training in management skills etc.

3. Interestingly, as Chair of the Education Board of the BOA, we are looking at Post CCT Fellowships at present and how we would construct them to provide not only on-going training and service, but also how they are going to gain skills in management etc. There is no doubt that the BOA believes that Post CCT Fellowships are very important. It allows trainees to hone their clinical skills and develop a specialist interest but they must be for a defined period of time otherwise there is indeed a risk of creating a sub-consultant service.

4. As Training Programme Director I now insist that trainees are unable to go on fellowships until they have obtained their CCT. Interestingly the other Programme Directors in London have followed suit and the rest of the country appears to be following.

5. Whatever happens, it is imperative that the RNOH preserves the firm structure and maintains the excellent training and teaching that we already provide. The experience from trainees when they come to the RNOH, having been in systems that are (shift) is one of relief in that they know which patients they have to look after. Further, they have regular contact with their trainer and I am sure it is the best way of training.

6. The major benefit of fellows is, in my view, flexibility and allowing consultants in busy units to meet the demands of practice. Certainly in our joint reconstruction/sarcoma service, maintaining this flexibility is vital to us achieving our target.
In your conclusions I agree that each firm and its structure will be very different, but I do believe that they are important to us as an organisation in maintaining flexibility and, in terms of the junior fellows, allowing us to increase our publication rate.

I do not believe that all replacement fellow posts need competitive recruitment processing including external advertisement. For instance, in the junior fellow posts that are doing research, they usually select themselves by coming to see one of us with their CV’s and we make an appropriate decision. We take on individuals who are, we hope, going to make the grade and become successful specialist trainees, and I do not think we need at that level to have an appropriate competitive recruitment process. it has worked extremely well to date and I do not think needs changing.

As regards senior fellows, these are going become very sought after posts and I totally agree, as happens already in the joint reconstruction unit, that these posts are indeed advertised and appointed appropriately. It is very important to realise that one-size does not fit all and there are different ways of doing things.

I am very supportive of looking at the PROMS review data and seeing what comes out of this and it is imperative that our patients continue to receive the highest quality care.

I totally agree the appointment of a senior fellow should not be instead of a consultant where a full consultant appointment would be more appropriate. However, do not lose the ability to be flexible, otherwise some firms will run into problems in hitting targets.

Where there is scarce theatre or clinic capacity, RNOH consultants I note will receive priority over RNOH fellows in allocating this capacity but if you take spaces allocated to fellows away from firms now, you will run into problems with access targets. If theatre space is taken away from current fellows, these jobs will become unattractive and we won't be providing the training they so require, and we will fail to recruit. Further, we will have firms over-whelmed with work and unable to hit targets and you should be aware of that.”

4.1. It would not be appropriate for the RNOH to have a generic policy for or against the use of Clinical Fellows within the workforce – each case needs to be considered on its merits. It is, however, important to be clear as to the circumstances where the use of clinical fellows is appropriate and where it is not appropriate.

4.2. Establishment control processes appear to be weaker for this staff group than other staff groups – as evidenced by the fact that 2 fellows staff are in post without formally being made part of the funded establishment. This should not be possible if the standard Trust processes had been applied before these staff were put on the payroll – this process is policed by the Trust’s vacancy control panel.

5. Recommendations : Next Steps

5.1. The following headline criteria would be expected to be applied in future business for consideration of Clinical Fellow appointments:

5.1.1. Previous Fellows appointments have not always had a full business case approved by Exec Team, particularly if external funding sources had been agreed locally within the unit. All Future new Fellows appointments will require
a business case, approved by the Executive Team prior to appointment. This will include a review of clinical workload and training, research and education elements of the job plan. This is now in place.

5.1.2. All replacement Fellows posts will follow an appropriate competitive recruitment process including involvement of RNOH Consultants, HR, management and external advertisement. This requirement has been in place formally for the last 2 years.

5.1.3. The post should assist succession planning for future sub-specialist consultant workforce and should therefore contain supervised time dedicated to training needs – the necessary job plan for the individual and supporting capacity for this will be demonstrated and signed off as part of the business case for approval process for new fellow appointments.

5.1.4. The posts should support piloting new ways of working that require senior clinical supervised by a consultant but do not require direct full consultant level involvement – for example supported discharge and other Transformation programme service changes.

5.1.5. The appointment should not diminish the quality of care for patients and receive full consultant supervision – the PROMs review needs to clearly establish any evidence of links between PROMs ratings and seniority of individual carrying out the procedure.

5.1.6. The appointment will not be instead of a consultant where a full consultant appointment would be more appropriate.

5.1.7. Where the post is funded via industry or other commercial or non-commercial grant funding, the basis of the funding will be documented, transparently communicated to the Trust and held on the individual’s file.

5.1.8. Where there is scarce theatre or clinic capacity RNOH consultants will receive priority over RNOH fellows in allocating capacity.

5.1.9. A Theatre Capacity Prioritisation Group will be set up with Clinical Director and Executive Director membership to recommend a transition plan for assigning theatre capacity to existing consultants or those appointed to start in the future, prioritised over and above current Fellow/Registrar led lists.

5.2. Establishment control processes for fellows need to be re-emphasised and re-applied consistently to ensure the same processes are in place for Clinical Fellows as all other staff groups.