NON CONSULTANT CAREER GRADE DOCTORS – AN IMPORTANT PART OF THE PAEDIATRIC WORKFORCE

Background

Non consultant career grade doctors (NCCGs) have traditionally formed a large part of the paediatric workforce. Much of the work in the community was, and in some cases still is, carried out by CMOs and SCMOs. In 1987 staff grade posts were introduced. A proportion of CMO’s and SCMO’s transferred to staff grade and Associate Specialist posts. Since “Achieving a Balance” was published in 1987 there has been concern about the grade highlighted in a number of reports (Staff grade doctors – towards a better future – RCP, 1993 and Meeting the Educational Needs of staff grade doctors and dentists, SCOPME, 1994). The RCP have recently made recommendations for improvement in the career structure of NCCGs. They highlight the main problems which apply equally to paediatrics.

- Poor career advice before entry.
- Variable work content – sometimes at an inappropriately high or low level.
- Variable supervision.
- Poor educational opportunities
- No external checks on competence.
- Limited – or non existent – career progression.

Recent Dept. of Health Reports

1. A Health Service of All the Talents: Developing the NHS Workforce

This was a major review of all aspects of the NHS workforce. Its aim was “to determine how to develop a workforce with the skills and flexibility to deliver the right care at the right time to those who need it – a workforce which has the right number of staff deployed in the right places and working to the maximum of their ability.”

With regard to NCCG doctors it states:

5.69 “A significant number of doctors and dentists with varying qualifications and skills are employed as staff grades, associate specialists and in NHS Trust-specific grades. They provide service support but are often overlooked in terms of career progression, training and development and continuing education. We are concerned that the number of such doctors has increased significantly in recent years in an unplanned way, often in response to short-term problems. While there will continue to be a need for such staff in the future we believe that, as with other staff, posts should be properly planned and linked to service plans. We also believe that steps should be taken to provide a proper career structure for such staff, which will see them as providing a valuable and valued role within the hospital and community health services.”
5.70 “In particular we see it as important that there is scope for staff in specialist training to step out of training posts and undertake a period in service posts and then return to the training ladder, and for staff who are employed in service posts to have better opportunities to re-enter training.

Steps should be taken to provide a proper career structure for staff employed as non-consultant career grades (e.g. staff grades, associate specialists and other Trust-specific grades), which will see them providing a valuable and valued role within the hospital and community health services.”

There are current discussions taking place between the BMA and DH regarding a “single spine” for NCCGs with progression upwards related to agreed performance.

2. The NHS Plan

This is the government’s plan of how the massive increase in spending on the NHS will be used to provide a significantly reformed service to better serve patients.

The report envisages an expansion of the consultant workforce by 30% over the next few years moving towards a service delivered by fully trained staff. The report states:

• “Over the next decade there will be an unprecedented expansion in the number of consultants working in the NHS. It will be vital to ensure the NHS is getting the maximum contribution possible from both existing and new consultants.
• Expansion on this scale also creates the opportunity to ensure that there is a clear career path for all senior doctors. We have examined two options here. The first would involve expanding the number of non consultant career grade doctors, often on trust specific contracts. This option would allow the NHS to get more fixed clinical sessions from senior doctors without competing with private practice and it will be kept under review.
• The second option is to make hospital care a consultant delivered service, where there is a clear career structure so that doctors have certainty about how they will progress and where contractual obligations to the NHS are unambiguous. It is this option that both the professions and the Government support in principle. Its implementation, however, will depend upon a new consultants’ contract.”

There is also to be a major investment in personal development and training:

• “We will ensure more help with personal development and training: by investing an extra £140 million by 2003/04 to ensure that all professional staff are supported in keeping their skills up to date and to provide access to learning for all NHS staff without a professional qualification.”

Revalidation

There has been increasing concern over the past few years regarding the poor performance of a small minority of doctors of all grades. The response to the concerns raised by a few high profile
cases has included an NHS consultation document – “Supporting Doctors, Protecting Patients” and a recent GMC document: “Revalidating Doctors – Ensuring standards, securing the future.”

It is almost certain that all doctors on the medical register will have to undergo a process of revalidation. It is also likely that the Royal Colleges will have a major part to play in this. In the GMC document one of the roles of the Colleges will be:

“Producing validated information about the current performance of members/fellows that could be accepted for revalidation. This could include Continuing Professional Development (CPD) evidence.”

It is, therefore, very likely that the majority of doctors practising in the UK will have to be a member of, or associated with, a Royal College in order to monitor CPD requirements. For paediatricians this will usually mean the RCPCH although some might be registered with other Colleges e.g. Faculty of Public Health Medicine.

**Workforce Survey**

Paediatrics has a higher proportion of NCCGs than any other specialty largely because of its historical community career structure. The Royal College of Paediatrics and Child Health has been concerned about the plight of NCCGs and in November 1998 set up a working party to review the issues and make recommendations. The first task was to determine how many NCCGs there are working in paediatrics.

In 1999 Dr. Sheila Shribman undertook a workforce survey for the RCPCH. A census form was sent to all clinical directors and an excellent 92% have responded.

The results are summarised in the tables in Appendix 1.

NCCGs are a major part of the trained paediatric workforce being 39% by number of doctors and 36% by WTE. Three quarters are female. The proportion of consultants/NCCGs varies little across the regions of England 36-43% although the London region has only 23%. In contrast Wales, Scotland and Northern Ireland have more than 50%. The reasons for the latter differences are not clear.

The NCCGs in paediatrics undertake a variety of tasks usually in either a hospital or a community setting. The workforce survey asked for information regarding the type of work undertaken and a summary is given in the following table.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Sub Specialists</th>
<th>Gen.Paed with Sub Specialty &lt;50%</th>
<th>Gen.Paed with Comm. &lt;50%</th>
<th>Comm/Gen 50/50</th>
<th>Comm. with Gen &lt;50%</th>
<th>Not specified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants (including Academics)</td>
<td>676</td>
<td>648</td>
<td>50</td>
<td>75</td>
<td>371</td>
<td>172</td>
<td>1992</td>
</tr>
<tr>
<td>Non Consultant Career Grades</td>
<td>119</td>
<td>112</td>
<td>62</td>
<td>57</td>
<td>826</td>
<td>136</td>
<td>1312</td>
</tr>
<tr>
<td>Other Grades</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>13</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>-------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>----</td>
<td>---</td>
<td>----</td>
</tr>
<tr>
<td>Total</td>
<td>798</td>
<td>765</td>
<td>112</td>
<td>134</td>
<td>1210</td>
<td>312</td>
<td>3331</td>
</tr>
</tbody>
</table>

There has been a rapid expansion in NCCG doctors since 1987. At first there was a ceiling on the number of such posts which was that they should not exceed 10% of the consultants in a particular specialty. However, there is now no limit or control and Trusts are free to appoint as many as they wish. The rapid expansion in SpR numbers following the Calman reform of junior doctor training in 1996 led to many hospitals, often for the first time, having a middle grade tier of junior doctors.

We now face a reduction in the number of SpRs to approximately half of the current number. This has and will lead many Trusts to think of appointing NCCG grade doctors to provide a middle tier of cover.

Posts fall into 2 main categories.

1) Posts both in the hospital and the community where NCCG’s undertake a relatively specialised role, at a defined level under consultant supervision. These might be at a general level e.g. Community CMO’s or at a more specialised level e.g. audiology, looked after children, adoption etc. in the community or helping to run a specialised service in hospital e.g. TB, enuresis, asthma and diabetic clinics. Many are also involved in teaching both medical students and postgraduate doctors as well as nurses. Most doctors find these posts quite satisfying.

2) The other type of post which has become much more common in recent years is where the NCCG doctor is appointed to provide a middle or even first tier of cover. Here they often work alongside career grade SHO’s or SpR’s and even take part in their training sessions. For an initial period these posts can be very satisfying for the doctor concerned but many become increasingly frustrated in the role. Within 2 – 3 years they are often very knowledgeable and competent yet most work at the same level as trainees who know much less and are less competent. The trainees then move on leaving the frustrated NCCG behind. This can lead to serious problems in relationships within a Unit. Consideration should be given to appointing to this type of post on a fixed term basis although serious thought would need to be given to where they went next. Re-entry into an SpR programme might be possible for those who have good experience.

The RCPCH recently produced “A Charter for Paediatricians”. The section on NCCG doctors is reproduced in Appendix II.

NCCG staff are an important part of the workforce and are likely to remain so, even if there is significant consultant expansion. The RCPCH wishes to provide better support to these doctors and makes the following recommendations:

**Recommendations**
1. **Appointment of new NCCGs**

- New posts should be created only when there is a clear service need for that grade of doctor. The Royal College of Paediatrics and Child Health continues to support the concept of a service provided by fully trained consultant doctors and this will require considerable consultant expansion. The appointment of NCCGs should not be contemplated where the work which needs to be undertaken is that which should be done by a consultant.

- There must be a job description which is reviewed by the Royal College of Paediatrics and Child Health Regional Adviser who will ensure that it fits with the model recommended by the College. (see appendix)

- The post should be advertised with a person specification and there should be a properly constituted appointments committee which will include a representative of the Postgraduate Dean and the Regional Adviser.

- At interview the RA’s duty will be to make sure that successful candidates understand the type of post that they are entering and what the implications are for career progression. They will point out that NCCG posts are not a training grade and that although entry or re-entry to the SpR grade is possible it will become progressively more difficult as SpR posts become more scarce. Time spent in a NCCG post will not count towards the 5 year training currently necessary to obtain a CCST. If re-entry to an SpR post is contemplated then as short a time as possible should be spent in the NCCG post.

2. **Continuing Professional Development**

- All NCCGs must undertake continuing education and professional development.

- In order to achieve this the job plans of such posts must contain sufficient protected time. It is recommended that at least 1 session each week is designated as professional development and that time is also given for audit.

- All NCCGs must participate in regular audit.

- Each NCCG should have a professional development plan which is reviewed on an annual basis by the Clinical Director during their annual appraisal.

- All NCCGs should have a named consultant mentor who may or may not be their consultant supervisor. The mentor’s role will be to provide ongoing career advice and support as well as to ensure that space for professional development is being given by management and taken by the doctor.

- NCCGs are entitled to study leave under Whitley Council regulations and this should be on the same basis as their consultant colleagues.

- The Royal College of Paediatrics and Child Health will monitor the CPD for all doctors who are registered with it for this purpose. All NCCG doctors should be encouraged to join the
College as associate members or if they have the MRCP/MRCPCH as full members. It will almost certainly become mandatory for all practising doctors to be registered with a College for this purpose to assist revalidation.

- There should continue to be a regular session at the annual Royal College of Paediatrics and Child Health annual meeting in York where NCCG doctors can meet and discuss issues of concern. If they wish such meetings could be attended by Senior College Officers.
- There should be a regular NCCG section in the College newsletter.
- Support for a relevant journal for CME.
- Academic Board should investigate educational needs of NCCGs at York and elsewhere.

3. **Career Progression**

The BMA and Department of Health are currently negotiating a new career path for NCCG doctors which they are negotiating with the Department of Health. If accepted there would only be one continuous spine with a natural progression from “junior” to “senior” associate specialist.

4. **Monitoring of NCCG posts**

The Royal College of Paediatrics and Child Health currently undertakes visits to assess hospital and community training posts for educational approval. They now invite NCCG doctors to meet them on these visits. The inclusion of these doctors in College visits, particularly to monitor compliance with CPD, will become a regular part of such visits in the future. The College visits are on a 3 year cycle so all posts should be visited in this time scale.

Prior to the College visit the College Tutor will be asked to identify all NCCGs in the Trust and they will be sent a short questionnaire to complete prior to the visit and will be invited to meet the committee. Any deficiencies in support being given to NCCGs will be identified by the visiting team and fed back to the medical and hospital management.

5. **Representation of NCCGs**

- The RCPCH currently has 2 associate member representatives on its governing body, Council. These are usually NCCG doctors. Each region including Scotland, Wales and Northern Ireland also has a NCCG representative.
- The College will set up a standing committee for NCCGs to ensure that their particular issues are adequately considered.
- The College will nominate an officer to represent the needs of NCCG doctors.

6. **Workforce Planning**

- NCCG doctors will be included in all future workforce censuses.
• The workforce planning and committee departments will establish a system to monitor advertisements for NCCG posts and to ensure that they are only appointed according to College guidelines.

7. **The Role of the Department of Health/NHS-E**

The DH/NHS E should be urged to put pressure on Trusts only to appoint NCCG doctors according to College and BMA guidance.
### APPENDIX 1

#### Main Grades by Gender
Consultants including Academics (No. of Doctors)

<table>
<thead>
<tr>
<th>Grade</th>
<th>Male</th>
<th>Female</th>
<th>DK or Blank</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants (including Academics)</td>
<td>1180</td>
<td>800</td>
<td>12</td>
<td>1992</td>
<td>59.8</td>
</tr>
<tr>
<td>Non Consultant Career Grades</td>
<td>284</td>
<td>988</td>
<td>40</td>
<td>1312</td>
<td>39.4</td>
</tr>
<tr>
<td>Other Grades</td>
<td>14</td>
<td>12</td>
<td>1</td>
<td>27</td>
<td>0.8</td>
</tr>
<tr>
<td>Total</td>
<td>1478</td>
<td>1800</td>
<td>53</td>
<td>3331</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

#### Main Grade by Gender
Consultants Including Academics (WTE)

<table>
<thead>
<tr>
<th>Grade</th>
<th>Male</th>
<th>Female</th>
<th>DK or Blank</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants (including Academics)</td>
<td>1159</td>
<td>744</td>
<td>12</td>
<td>1915</td>
<td>63.6</td>
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<tr>
<td>Non Consultant Career Grades</td>
<td>269</td>
<td>768</td>
<td>40</td>
<td>1077</td>
<td>35.7</td>
</tr>
<tr>
<td>Other Grades</td>
<td>12</td>
<td>9</td>
<td>1</td>
<td>22</td>
<td>0.7</td>
</tr>
<tr>
<td>Total</td>
<td>1440</td>
<td>1521</td>
<td>52</td>
<td>3013</td>
<td>100.0%</td>
</tr>
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</table>
### Region by Main Grade Consultants Including Academics

<table>
<thead>
<tr>
<th>Region</th>
<th>Consultants Including Academics</th>
<th>Non Consultant Career Grades</th>
<th>Other Grades</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>128</td>
<td>91</td>
<td>3</td>
<td>222</td>
</tr>
<tr>
<td>London</td>
<td>392</td>
<td>122</td>
<td>7</td>
<td>521</td>
</tr>
<tr>
<td>North West</td>
<td>241</td>
<td>171</td>
<td>1</td>
<td>413</td>
</tr>
<tr>
<td>Northern &amp; Yorkshire</td>
<td>230</td>
<td>133</td>
<td>3</td>
<td>366</td>
</tr>
<tr>
<td>South East</td>
<td>242</td>
<td>182</td>
<td>3</td>
<td>427</td>
</tr>
<tr>
<td>South West</td>
<td>129</td>
<td>67</td>
<td>2</td>
<td>198</td>
</tr>
<tr>
<td>Trent</td>
<td>161</td>
<td>98</td>
<td>1</td>
<td>260</td>
</tr>
<tr>
<td>West Midlands</td>
<td>176</td>
<td>106</td>
<td>3</td>
<td>285</td>
</tr>
<tr>
<td>Total – England</td>
<td>1699</td>
<td>970</td>
<td>23</td>
<td>2692</td>
</tr>
<tr>
<td>Wales</td>
<td>87</td>
<td>98</td>
<td>2</td>
<td>187</td>
</tr>
<tr>
<td>Total – England &amp; Wales</td>
<td>1786</td>
<td>1068</td>
<td>25</td>
<td>2879</td>
</tr>
<tr>
<td>Scotland</td>
<td>162</td>
<td>196</td>
<td>1</td>
<td>359</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>44</td>
<td>48</td>
<td>1</td>
<td>93</td>
</tr>
<tr>
<td>GRAND TOTAL</td>
<td>1992</td>
<td>1312</td>
<td>27</td>
<td>3331</td>
</tr>
</tbody>
</table>
APPENDIX 2

Extract from a Charter for Paediatricians

Non-Consultant Career Grades (Section 9)

1) The staff grade was intended to provide a secure and satisfactory career for doctors who do not wish or are unable to train for consultant status. They are responsible to a consultant and they do not have a continuous 24 hour responsibility for their patients.

2) The 1997 staff grade contract explicitly allowed staff grade doctors to undertake out-of-hours duties.

3) After a certain period, staff grade doctors may apply for regrading to associate specialist. This is not an automatic right and an appropriately constituted panel must interview the doctor. Associate specialists are also responsible to a named consultant. The BMA has detailed information on these grades and recommended job descriptions.

4) Associate Specialist posts can now be advertised in their own right. After the implementation of the “single spine” recommendations, it is proposed that the non-consultant career grades will be unified into a single grade. The title for this has not yet been decided but it is hoped that it will be one that reduces the confusion surrounding the different titles and does not include the word “grade.”

5) Staff grade doctors should receive proper career advice. The grade was not originally intended to be a step towards a consultant post and the SCOPME report showed that many doctors mistakenly entered this grade intending to become consultants. There should be clear guidance for trainees that:

- NCCG posts are not currently an alternative route to consultant posts – doctors have usually been expected to remain in these posts for their whole career.
- Time spent in such a post is unlikely to count towards a CCST.
- Career advice should be sought from consultants, postgraduate deans and specialty advisers who should recognise that for some this career pathway can have benefits.

6) The regional adviser should review the job plan to ensure that:

- 2 sessions for staff grades and 2 NHDs for associate specialists are set aside for CPD and audit per week.
- The work is appropriate
- There is supervision from a named consultant.
- The on-call rota is not too onerous.
- There is some involvement in management and education to improve the status of these grades.

7) There should be an appropriately constituted appointment committee including a college adviser or specialty adviser. The college nominee should ensure that the applicant
understands the implications of the post for future careers and what goals they can expect to achieve.

8) An elected NCCG representative sits on College Council and regional committees should have similar representation. This representative should work with regional advisers in approving NCCG job descriptions. The College currently has a working group looking at the numbers and career paths of NCCG doctors.

9) Ordinary membership or associate membership of the College should be encouraged so that CPD and revalidation issues can be addressed.

10) The specialist Training Authority may need to reconsider the issue of re-entry to training grades and time spent in NCCGs with relation to the CCST.

11) The College is in consultation with the GMC over plans for revalidation of NCCGs.

12) NCCGs should be as equally encouraged, supported and welcomed within a department as are their Consultant colleagues.