Non consultant career grade doctors: past, present and future

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Staff grades were created in order to resolve the issue of the thousands of locum registrars and SHOs working within the NHS without security or tenure. The grades were intended to achieve balance with secure jobs, but largely failed in this intent due to trust freedoms and abuse – which saw NCCGs used to plug staffing gaps without appropriate support or protection – and an undermining of the status of doctors in these positions. Some NCCGs had unrealistic expectations of the post, overestimating their chances of becoming a consultant, or conversely seeing the post as lacking any prospects. Before the European Specialist Medical Qualifications Order (ESMQO) in 1995, the chances of becoming a consultant *were* real, if distant; they depended on the doctor's medical degree, training, experience and ability to fill the post. After 1995, this avenue of advancement was closed.

However, this is not necessarily a cause for despair: the career grades should not be seen as inferior to consultant posts, merely different. There is nothing wrong with concentrating on teaching and clinical care without the distractions of other duties such as management and organisation.

The future should see the development of the staff grades, concentrating on seeing them as performing valuable functions and finding ways to realise their full potential. The question of allowing NCCGs to re-enter and complete training should also be explored; this, however, presents problems since the posts are not, in their purpose or structure, training posts, and making them so might lessen their usefulness. Staff grades should also be given new contracts that ensure a good standing and salary.

NCCGs: a vision for the future

The NCCG is a 'non-satisfactory non-career non-grade'. Problems with the position include:

- an enormously valuable contribution that is largely unrecognised
- a lack of career structure and career opportunities
- inadequate access to training
- the variable quality of supervision
- differences in grades, title and remuneration
- a profusion of different job content and work patterns
- serious questions about equality.

The situation of NCCGs and the NHS as a whole could be improved by a clear definition of role and contribution, clear criteria for entry, progression and exit, allied to a better understanding of the competencies required for the role, and better access to training, education and continuing professional development (CPD) in order to aid the acquisition and maintenance of those competencies. Clear lines of clinical and managerial accountability for the post, more opportunity to step on, step off and step between pathways and a corresponding pay structure would also be helpful.

Some valuable developments are already underway within the NHS. These include the extension of appraisal and revalidation, the modernisation of pay structures, and the 'Improving Working Lives for Doctors' initiative. Now is the time, however, to

Conference programme

NCCG's: a vision for the future
Mr Andrew Foster, director of Human Resources, Department of Health, London

Prospects for progression within the NCCG Grades
Dr Peter Hawker, CCSC, British Medical Association, London

How to improve your prospects
Dr Kate Bullen, Frenchay Hospital, Bristol

Recognising the critically ill medical patient
Professor Tim Evans, Royal Brompton Hospital, London

Overseas doctors and the specialist – why do few overseas doctors become consultants?
Mr Awani Choudhary, British Medical Association, NCCG Subcommittee

Is the NCCG grade a good option for flexible working?
Dr Shelagh O'Riordan, Kent and Canterbury Hospital

How not to be exploited – job plans and appraisal
Dr Rodney Cove-Smith, James Cook University Hospital, Middlesbrough

CPD and the NCCG Grade
Dr Michael Watson, Federation CPD Director, Edinburgh

Optional and discretionary points and how to get them
Dr Greg Dilliway, British Medical Association, NCCG Subcommittee

begin a more widespread process of reform in which the views of the NCCGs themselves must be taken into account.

Overseas doctors and the specialist: why do few overseas doctors become consultants?

Overseas doctors are necessary because the NHS is not self-reliant, and because it is necessary to take some of the pressure off those doctors who are supposed to be training but who are actually doing most of the work. There is a perception, however, that the overseas doctors are not capable of attaining the standard of medicine required to become consultants. This perception belies the difficulty of the Professional and Linguistic Assessments Board (PLAB), which is not only an assessment of linguistic competency, but also a tough test of clinical skills.

Racism in medicine: an agenda for change[1], a publication of the King's Fund, also gives the impression that there is a culture of corporate repression. This repression might be motivated by a fear that the 'master apprentice' will soon become the master. The NHS should make an effort to ensure that the experience of overseas doctors, who as NCCGs often teach SHOs and SpRs, is counted. There should also be a structured training programme for all, and an ability and willingness on the part of postgraduate deans to improve job prospects for overseas doctors.

Is the NCCG grade a good option for flexible working?

The term 'flexible working' refers to all patterns of work that differ from a standard 40-hour week (with or without additional on-call time). It includes part-time work, job sharing, flexible retirement, the Flexible Careers Scheme and flexi-time, where some variation in the way one contributes a set number of hours is allowed. It is popular amongst NCCGs; in 2001, for example, 42% of those polled were working part-time.

Flexible working is high on the Department of Health's list of priorities. This is because of recruitment problems (18% of trained doctors are not working in the NHS, and flexible working may be a way to encourage them back), the increasing number of female doctors, and changing attitudes to the work/home life balance and the culture of long working hours. The Department of Health's 'Improving Working Lives' initiative recognised that staff are happier and work better for patients when they are able to strike an acceptable balance between their professional and personal lives, and outlined a range of policies designed to encourage the implementation of systems of flexible working. Trusts are assessed against performance targets, and will be expected to have put the document into practice by 2003, so there is a chance that these ideas will not be left on the shelf.

Job-sharing

Two or more employees share responsibility for what would be one full-time job. It is advantageous to the employer because increased motivation and a wider range of skills mean that the two halves are often greater than the whole. A problem might arise when one of the sharers departs; however, there are job share registers to help with this.

Career breaks

All grades of staff who have completed 24 months in the NHS are entitled to career breaks, with the guarantee of the current or a similar post at the end of the break. They usually last between one and three years, and can be taken for a variety of reasons, including travel, education and the care of dependants. Those on career breaks are not precluded from working elsewhere.

Flexible Career Scheme

This allows doctors to move through periods of part-time work or take career breaks, and is available to those who want to work less than 50% of the time. It involves sufficient medical practice for revalidation and CPD, and the doctor will have an educational supervisor and appraisal process.

Flexible retirement

Flexible retirement aims to staunch the flow of experienced doctors leaving the NHS. There are four choices:

- 'Winding down', where pension benefits are calculated on whole-time equivalent pay
- 'Stepping down', where, for example, a doctor might stop doing on-call work
- Coming back from retirement, which incurs no adverse effects on a pension
- Joining a winter register, and working for short periods in order to help at times of high pressure.

Parental leave

Parents whose children were under five on 15 December 1999 are eligible for parental leave. It allows 13 weeks unpaid leave for each child, and must be taken to look after the child.

Scottish Hospital Doctors Retainer Scheme

This is for doctors returning to practice or remaining in practice but unable to do even half-time work. It includes clear educational goals, usually involving two or three sessions.

In summary, the NHS is moving towards greater flexibility, and there are many doctors working in unusual ways which are not simply 'part-time'. Advice can be sought from from the BMA, the RCP and other medical personnel.

How not to be exploited: job plans and appraisal

The Royal College of Physicians recommends that all staff grade doctors should have a job plan agreed with their trust. Staff grade doctors should be responsible to a named consultant, with whom they should have agreed the limits and scope of their

duties. Within those limits they should have the freedom to make clinical decisions.

In the BMA-recommended job plan doctors are expected to specify where they are, and what type of work they are doing, for each morning and afternoon of the working week. They are also expected to list how many hours they spend on each type of duty, for example administration or teaching. The annual appraisal meeting should be a review of progress against previously agreed objectives, an opportunity to raise any concerns that may exist and an opportunity to agree, with the appraiser, some objectives for the current year which will form the basis of a personal development plan.

CPD and the NCCG grade

The three Royal Colleges of Physicians established the CPD scheme six years ago as a response to the GMC document *Good medical practice*[2], which stated that doctors have a responsibility to keep knowledge and skills up to date, participate in educational activities and maintain and develop competence and performance. A development of CPD is now taking place, consistent with revalidation requirements and Academy of Medical Royal Colleges' principles.

CPD is simple to operate, takes into account the fact that people learn in different ways, assists with appraisal and depends on verifiable data. It offers a range of activities, both clinical and non-clinical. It can be recorded either on paper or online. The paper option is a simple way of rating quality, but can be more bureaucratic than the online 'CPD Diary', which requires no further verification of approved external events beyond entry into the database[3].

The Federation of Royal Colleges of Physicians' CPD scheme encourages and facilitates a planned approach to professional growth, and supports the needs of appraisal. It is an initiative that the Federation will continue to develop.

Optional and discretionary points and how to get them

Associate specialists at the top of their incremental scale, new appointments with sufficient experience, and staff grade doctors at the top of their incremental scale and on a new contract are eligible for optional and discretionary points. Those below automatic increments are amongst those who are not. Their acquisition brings financial advantage, as well as kudos and personal satisfaction.

References

1 Coker N (ed). *Racism in medicine: an agenda for change*. London: King's Fund, 2001.

2 General Medical Council. *Good medical practice*. London: GMC, 2001.

3 The CPD Diary can be accessed at www.rcplondon.ac.uk/members/CPDdiary/index.asp