

# Non-consultant career grade doctors: past, present and future

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## Introduction

There is still uncertainty and confusion over which grades of doctor are encompassed by the title ‘non-consultant career grade doctors’ (NCCG). They are staff grade doctors and the more senior associate specialists. Also included are doctors working in the community, previously called clinical medical officers (CMOs) and senior clinical medical officers (SCMOs), although doctors in these groups should all be re-graded as staff grade or associate specialists in the near future. In addition some trust grade doctors, working in non-standard posts, at levels above the senior house officer (SHO) grade are also NCCGs. NCCGs are variously referred to as senior doctors, or increasingly as middle grades, with little understanding of the wide range of experience and competencies gained in these posts.

NCCGs make a large contribution to the NHS. They spend 90–100% of their time on direct clinical care and form 25% of medical staff outside those in the training grades. In accident and emergency departments, 50% of non-training staff are NCCGs and in general medicine the figure is 80% (Tables 1 and 2).<sup>1</sup>

Although at present doctors in our grades have specific concerns, the NHS as a whole is undergoing immense change and it is far from clear where NCCG doctors will fit into the future secondary care and community career structures. Currently proposed changes for NCCG doctors must be considered within this wider context.

## NCCGs: a vision for the future

At our first conference four years ago, the urgent need for reform of the NCCG grades was agreed and discussed under the title ‘a vision for the future’. If this vision is to be realised, the current difficulties will need to be properly addressed. These are:

- lack of status and recognition
- (perceived) exploitation/discrimination
- lack of consistent definition and names for the grade
- minimal opportunities for training and career progression.

Since this conference, a number of proposed reforms have tried to address these issues, including Choice and Opportunity<sup>2</sup> and Modernising Medical Careers

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**Table 1. Numbers of total staff, consultants and NCCG doctors in two specialties (excludes training grades).<sup>1</sup>**

	All staff in specialty	Consultants	AS	SG	HP/CA	Other CHS	Total NCCGs in specialty
Accident and emergency	3,842	596	84	439	42	0	565
General medicine	4,424	93*	43	209	119	5	376

All figures are staff numbers expressed as full time equivalents. \* The origin of this figure is uncertain. It may reflect the number of consultants in acute medicine rather than the total number of consultants doing general medicine and their own specialty. AS = associate specialist; CA = clinical assistants; CHS = community health service; HP = hospital practitioners; SG = staff grade doctors.

**Table 2. NCCG doctors in two specialties expressed as percentage of all doctors in non-training grades.<sup>1</sup>**

	Consultants in specialty	Total NCCGs in specialty	Total staff non-training	NCCGs as % of non-training staff
Accident and emergency	596	565	1,161	48.7%
General medicine	93	376	469	80.2%

All figures are staff numbers expressed as full time equivalents.

(MMC).<sup>3</sup> This resulted in the Government agreeing ‘a cash envelope’ for a new NCCG contract and appointing NHS employers to enter into negotiations which began formally in May 2005. At the time of this conference the negotiations were ongoing and no agreement had been finalised.

It is vital that these reforms should be of benefit to doctors. Doctors should be able to progress through a new career structure allowing them to gather evidence of competencies, which in turn will help them to achieve appropriate recognition and reward. It should also become much easier to re-enter training at different points on the career ladder. It is important that these changes are beneficial for the service and for patients too. NCCG doctors, who are a trained and competent workforce, must continue to provide a high standard of care valued both by employers and patients.

### Assessment and NCCG doctors

Historically NCCG doctors were thought to have completed training and, apart from appraisal, were not seen to be in need

of assessment. It is now clear that assessment methods must be developed for this group:

- to enable progression within a single career pathway
- to allow movement in and out of the training grades
- for applications under Article 14 to join the specialist register
- to provide evidence of competence for revalidation.

It is likely that similar assessment methods to those developed for specialist registrars (SpR) will be used. These include mini-CEX (mini-clinical evaluation exercise), DOPS (directly observed procedural skills) and multisource feedback (previously known as 360 degree assessment). Communication skills may be further assessed with the help of patient questionnaires and tests of knowledge will also continue to be used.

The ultimate aim is to integrate the results of the different assessments to provide an overall picture of the skills of an individual doctor. The results can also be used under the headings of *Good medical practice*<sup>4</sup> for appraisal and for those applying to enter the specialist register as described below.

### Continuing professional development

All NCCG doctors need a record of their continuing professional development (CPD) for appraisal, revalidation and career development. The online CPD system of the Royal College of Physicians (RCP) is an ideal way to record this and is as suitable for NCCGs as it is for consultants. An audit is carried out each year of 5% of registrants to ensure quality and accuracy of CPD recorded. In the future links will be created to appraisal and revalidation, and there is a plan to approve certain web-based learning packages. This will allow up to seven annual credits for ‘distance learning’. Online CPD will continue to be an essential tool and is available to all NCCGs in medical specialties.

### PMETB and Article 14 of the General and Specialist Medical Practice (Medical Education, Training and Qualifications) Order 2003

Many NCCG doctors undertake work similar to that of consultants and accept a high level of responsibility. They have been unable, however, to apply for consultant posts, as their names are not on the specialist register. In 1997, some applied for entry to the specialist register under mediated entry, but at that time the doctor’s experience in their specialty could not be taken into account. Article 14 has removed this anomaly and now allows these doctors to apply to enter the register after providing evidence which can now include ‘experience’ as well as qualifications and training wherever obtained. If this combination is thought to be ‘equivalent’ to that of a successful certificate of completion of training (CCT) applicant, the application will succeed and once on the specialist register, the doctor can apply for consultant posts.

In medical specialties these applications are sent to the new Postgraduate Medical Education and Training Board (PMETB), who send them, once complete, to the RCP Joint Committee

#### Conference programme

##### ■ Opening remarks and welcome

Dr Venkat Mahadevan, Chair, Standing Committee for NCCG Doctors, Royal College of Physicians (*Conference organiser*)

##### ■ How to improve your career prospects

Dr Gregg Dillaway, Joint Deputy Chair, Staff and Associate Specialist Committee, British Medical Association

##### ■ NCCGs: A vision for the future

Mr Andrew Foster, Director of Workforce, Department of Health

##### ■ Update on the new contract for SAS (NCCG) Doctors

Mr Mohib Khan, Chair, Staff and Associate Specialist Committee, British Medical Association

##### ■ The work of PMETB and relevance to NCCG Doctors

Mr Paul Streets, Chief Executive, PMETB

##### ■ Pulmonary embolism

Dr Andrew Miller, Consultant Physician, Mayday University Hospital, Croydon

##### ■ The future NHS – what it means for doctors

Professor Dame Carol Black DBE, President, Royal College of Physicians

##### ■ The future of acute medicine

Professor Ian Gilmore, Consultant Gastroenterologist, Royal Liverpool University Hospital

##### ■ CPD and NCCG Grade

Dr Ian Starke, Director of CPD, Federation of Royal Colleges of Physicians, UK

##### ■ Assessment and NCCG Doctors

Winnie Wade, Director of Education, Royal College of Physicians

##### ■ Article 14 and NCCG Doctors

Mr Nicholas Grant, General Manager, JCHMT

on Higher Medical Training (JCHMT). A large number of RCP evaluators trained in each medical specialty assess and make recommendations on each applicant to PMETB, but it is PMETB who make the final decision.

PMETB came into existence in September 2005 and has far-reaching responsibilities for medical education and training. Article 14 applications are only one aspect of their work. It was reported at this conference that 267 applications in medical specialties had been received at PMETB, but that 11 had been assessed so far by JCHMT. Although it was acknowledged that the application process is complicated and time-consuming, the PMETB processing is becoming more streamlined and many more decisions are expected soon. It was emphasised that specialist registration obtained via the Article 14 route is exactly equivalent to that of a CCT holder.

Some optimism seems to be justified in that a number of the most highly experienced NCCGs may already be close to obtaining consultant appointments. PMETB Article 14 decisions, however, are likely sometimes to recommend a further period of training and at present there is no funding available for this. It will also be difficult for trusts to release these doctors from their service posts to train elsewhere and not all of this training will be possible in-house. This issue must be resolved if further training for eligible NCCG doctors is to become a reality.

### How can NCCG doctors improve their prospects?

Realistically the majority of doctors in these grades do not have the necessary training and experience to apply for specialist registration. Some have become demoralised and pessimistic about their chances of career advancement. The difficulties include poor status and the risk of exploitation. In light of this, should individual doctors abandon hope of advancement? Should they await developments from the proposed new contract, or take steps now that can only be beneficial in the long run? The obvious answer is to take a closer look at themselves, their jobs and departments. Forward planning to create a personal portfolio will bear fruit in the future. The portfolio should contain everything required for appraisal and revalidation as well as 'reflective notes', whereby a doctor records on a regular basis recent achievements, new knowledge and skills, and contributions to their department or trust. Additional roles can enhance job satisfaction, for example teaching, audit, or becoming more involved in departmental issues. Doctors also sometimes need to examine their own behaviour and their relationships with their colleagues. A mentor may help particularly if there are difficult issues, such as bullying, that are seldom easy to resolve.<sup>5</sup>

### Acute medicine in practice

The new medical specialty of acute medicine is particularly relevant to NCCG doctors who are well equipped to work in 'acute medicine units', especially if they wish to work flexibly, or with predictable shift patterns. All the safeguards previously mentioned will ensure that these posts are not seen as service posts with little prospect of career advancement, but as a fulfilling spe-

cialty both for those NCCGs who wish to re-enter training, and for those who prefer to remain as NCCGs.

### The future NHS

No reform of the NCCG grades should be considered without due attention to wider issues within the NHS. It is crucial that the new NCCG career structure dovetails into MMC in a way that is beneficial to both NCCGs and also to those junior doctors who see an NCCG post as a means of acquiring additional skills while waiting for a definitive training post. The effects of the European Working Time Directive (EWTD) on the medical workforce and a wish by many doctors for a better work-life balance apply as much to NCCGs as to others. Many challenges lie ahead for the NHS, including greater patient choice, practice-based commissioning and a redistribution of chronic disease management from secondary to primary care.

### The future NCCG doctor

Details are beginning to emerge of the new NCCG contract, but information is still limited. The associate specialist grade is likely to be phased out and the new career structure will consist of three levels with two thresholds. It is suggested that the associate specialist grade will be replaced by a new grade of doctors with CCT who will be accredited specialists with consultants being renamed as senior medical appointments. Not all of these proposals are to be welcomed by the doctors in our grades.

### Conclusion

NCCG doctors will continue to play an important role in the NHS for the foreseeable future. We will have a new name and hope that with this change in title will come the much needed improvements in status and career progression. It is also to be hoped that the other changes taking place alongside the development of our new career structure will benefit and not hinder the achievement of these goals.

### References

- 1 Department of Health. *Department of Health NHS hospital, public health medicine and community health service medical and dental workforce census, England*. Statistics (Workforce) Medical and Dental Analysis. London: DH, 2004.
- 2 Department of Health. *Choice and opportunity: modernising medical careers for non-consultant career grade doctors*. London: DH, 2003.
- 3 Department of Health. *Modernising Medical Careers: the next steps*. London: DH, 2004.
- 4 General Medicine Council. *Good medical practice*, 3rd edn. London: GMC, 2001.
- 5 Anita Houghton. *Know yourself: the individual's guide to career development in healthcare*. Oxford: Radcliffe Medical Press, 2005.