



# **Non-Consultant Career Grade Anaesthetists 1998**

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## SECTION 1 - INTRODUCTION

The number of non-consultant career grade doctors employed in the National Health Service (NHS) has grown rapidly in the last few years [1] and there have been changes in government policy including the introduction of revised terms and conditions of service for both staff grades and associate specialists [2,3]. The Royal College of Anaesthetists has published advice on appointment procedures for these grades [4].

The 1990 the National Health Service and Community Care Act allowed the setting up of NHS trusts with the freedom to offer new staff, including doctors other than those in the training grades, any terms and conditions of service. The national ceiling on staff grade numbers was formally removed in 1997 and employing authorities and trusts were made responsible for individual staff grade appointments.

The quality framework for Hospital and Community Health Services Medical and Dental Staffing, published in April 1997, [5] introduced new arrangements to replace controls on staff grade appointments.

The two main elements of the arrangements were that -

- (a) trusts would be expected to produce explicit information on their medical staffing plans and that this should be supported by the main purchaser and be consistent with the quality guidelines set out in the framework;
- (b) the local Medical Workforce Advisory Groups established under EL(96)68 would consider and advise on these plans in the context of the quality framework, which includes suggested staffing ratios.

This booklet replaces existing advice contained in the 1992 Association publication [6].

Sections 2 - 6 will consider and advise on terms and conditions of service for all grades and how they should be managed in the light of these changes.

Sections 7 -11 will consider each grade in detail.

## **SECTION 2 - RECOMMENDATIONS [1]**

These recommendations apply to all non-consultant career grades.

- (a) The Association strongly recommends that all appointments are to nationally recognised grades and that appointments should be to staff grade or associate specialist posts.
- (b) The Association of Anaesthetists does not support non-standard grades with variable terms and conditions of service.
- (c) All appointees should normally possess a postgraduate qualification (FRCA or FFARCSI)
- (d) The requirement for the possession of the FRCA may be waived if, in the opinion of the College assessor, the applicant has completed a programme of training and gained sufficient relevant experience to fulfil the requirements in the job plan. Those without the FRCA should not supervise trainees or work in isolated locations unsupervised.
- (e) Consultants responsible for these grades should ensure that professional support is available.
- (f) Provision should be made for continuing medical education (CME), continuing professional development (CPD) and audit.

## **RECOMMENDATIONS [2]**

Non-consultant career grades, regardless of post, will be of differing experience, have various contracts, job descriptions and work programmes. In order to ensure the maintenance of standards of patient care, the Association commends the following guidelines.

- (a) All appointees must have a job plan which reflects their training and experience. All appointees must be accountable to a named consultant and appropriate levels of supervision should be provided at all times.
- (b) Clinical work is to be undertaken as directed by the clinical director or named deputy who should monitor at regular intervals satisfactory clinical performance.
- (c) A minimum weekly commitment to anaesthesia of three notional half days or equivalent, including at least two clinical sessions and time to perform the necessary associated activities, for example pre-operative and postoperative care of patients.
- (d) All work programmes should include involvement in emergency work and the maintenance of resuscitation skills.
- (e) Contractual hours are not limited but it must be recognised that excessive hours of work may harm patient safety.
- (f) All practitioners in these grades should, as a part of their normal job plan, spend supervised time with a consultant.
- (g) Job plans should be reviewed annually.

### **SECTION 3 - APPOINTMENT PROCEDURES**

The introduction of the Quality Framework and the demise of regional manpower committees removed all controls on staff grade appointments and the necessity to get manpower approval for the appointment of associate specialists.

In any consideration of a career grade appointment, the following factors should be taken into account:-

- (a) the need to develop a consultant-based service;
- (b) overall consultant responsibility for patient care;
- (c) consultant cover both in and out of hours in the relevant speciality and, where necessary, in related specialties;
- (d) provision for the teaching of junior doctors and the supervision of both junior and career grade medical staff.

Non-consultant career grade posts should be established only where this is in the best interests of the service.

Non-consultant career grade appointments in the NHS are non-training appointments and are thus permanent career posts. Practitioners in these grades are valuable members of the anaesthetic team but opportunities for progress are limited and most practitioners who enter this grade will remain in the grade until they retire. Practitioners who wish to return to a training programme may find themselves at a disadvantage.

All such appointments are accountable to a named consultant and the ultimate responsibility for patients rests with that consultant (normally the clinical director but during out of hours work the consultant on-call). This applies to all non-consultant career grade posts within the NHS.

The Association of Anaesthetists encourages job sharing where appropriate.

## **SECTION 4 - THE SPECIALIST REGISTER**

The Specialist Training Authority (STA) of the Medical Royal Colleges advises the General Medical Council (GMC) on those names which should be included in the Specialist Register. This recommendation normally follows from confirmation by The Royal College of Anaesthetists that the trainee has successfully completed a period of training as laid down by the College.

In January 1997, it became a legal requirement that only doctors whose names appear on the Specialist Register are able to take up a substantive or honorary NHS consultant appointment.

Consultant appointments are subject to this statutory instrument but it does not apply to any other career grade post.

The initial transitional period, during which non-consultant career grade doctors could apply for inclusion in the specialist register, was extended by an amended version of the European Specialists Medical Qualifications Order in December 1997. The main change allowed experience as well as formal training to be taken into account. Any requirement for further training must be completed to the satisfaction of the GMC by the 1st December 2001. Only those with the FRCA can be considered. Those wishing to apply for consideration had to do so by 1st October 1998.

Following the transitional period, the only route to inclusion on the Specialist Register will be to complete the College requirements for the Certificate of Completion of Specialist Training (CCST). Non-consultant career grades will then have to compete with existing trainees for the available posts.

## **SECTION 5 - STUDY LEAVE/AUDIT**

There should be opportunities for further training, participation in regular continuing medical education and continuing professional development in line with the recommendations of the Royal College of Anaesthetists. Points should be awarded using the same mechanism as for consultants.

Study leave provision should be the recommended standard maximum of 30 days (including off duty days falling within the period of leave) in any period of three years for professional purposes related to the appointment within the UK.

Appropriate funding must be made available by a trust to ensure its successful achievement including paid time off in accordance with national agreements [7].

All non-consultant career grade anaesthetists should take part in regular departmental and hospital-wide audit and it is recommended that this is a regular fixed commitment in the job plan.

## **SECTION 6 - SUPPORT FOR NON-CONSULTANT CAREER GRADE ANAESTHETISTS**

Non-consultant career grades require supervision appropriate to their experience and should not normally be involved in training unless they are in possession of the FRCA. They do not take ultimate responsibility and therefore need to understand the lines of accountability within the department and their own personal responsibility [8].

On appointment, they are commonly made accountable to the clinical director or chairman of division and their duties are subject to the rota co-ordinator. There should be an induction procedure for all new staff and, like any newcomer, they may require assistance with accommodation, catering, childcare etc. The anaesthetic department secretary often plays a key role in assisting during the settling in period and facilitating contacts with the appropriate people but this should be supervised by the accountable consultant.

After six months to a year, as with any member of staff, it is appropriate to ask the new appointee to name a preferred mentor.

The mentor, plus the appointee, plus the unit training director should decide on study leave and continuing professional development needs in line with the individual's interests and the department's needs. Sickness absence should be carefully monitored as it may be a sign of stress or unhappiness [9].

The appointee should be encouraged to contribute fully to the organisation and activities of the department. They should be included in all appropriate meetings as well as educational activities.

## **SECTION 7 - ASSOCIATE SPECIALIST**

The associate specialist grade is a permanent career grade of limited responsibility, introduced in 1964. It is a senior hospital post with an inclusive professional contract similar to that for consultants [10].

It would normally be suitable for doctors committed to a career in the hospital service who are unable to complete the training programme necessary for inclusion in the Specialist Register or those who do not wish to accept, for whatever reason, the full responsibility of a consultant post.

The associate specialist is accountable to a named consultant.

### **Qualifications**

Under national terms and conditions of service, a practitioner is eligible for appointment to the associate specialist grade provided that they have:

- (a) completed ten years of medical work, either a continuous period or an aggregate since attaining a primary medical qualification acceptable to the General Medical Council (GMC) for full, limited or temporary (but not provisional) registration;
- (b) served a minimum of four years in the registrar, specialist registrar or staff grade. The applicant should have served at least two of these years in anaesthesia. Equivalent service is also acceptable with the agreement of the College regional adviser.

These are minimum requirements. All appointees would normally be expected to possess a higher qualification, for example FRCA.

### **Appointment procedures**

The normal route for appointment to the associate specialist grade should be by personal regrading without advertisement.

Recent changes in legislation mean that associate specialist posts can now be advertised and are no longer necessarily a personal appointment or subject to manpower controls. Trusts, therefore, need seriously to consider the need for

the post and whether or not a consultant appointment would be more appropriate.

The recommended appointment committee should comprise, as a minimum, the following:

- (a) a senior manager from the trust;
- (b) a consultant (or associate specialist) from the trust;
- (c) a senior hospital doctor, nominated by the College.

For posts which have been advertised, there should be a further College representative. The trust may appoint extra members to the committee as necessary [3].

### **Contractual arrangements [11]**

The contract of the associate specialist is similar to that of a consultant, being described in terms of notional half days (NHDs) defined as 3\_ hours worked flexibly.

Associate specialists have the option of a whole time, maximum part-time or part-time contract.

Whole time and maximum part-time associate specialists are expected to devote substantially the whole of their professional time to NHS duties and there is a minimum requirement of ten notional half days per week for both contracts.

Associate specialists have the right to undertake private practice and earnings are unlimited for part-timers and maximum part-timers. Full-timers are only allowed to earn up to ten per cent of their gross NHS earnings.

Part-time contract holders will have a work commitment of between one and nine notional half days and are paid one eleventh of the whole time associate specialist salary for each NHD.

### **Discretionary Points [12]**

Performance supplements introduced in 1991 have now been replaced by discretionary points.

Associate specialists on the maximum of the scale are eligible for the award of discretionary points.

There are four discretionary points on top of the pay scale and the fourth point is equivalent to fifteen per cent of the maximum of the salary scale. Employers have discretion on the number of points to be granted in any individual case.

Criteria for the award of discretionary points are that the practitioner has demonstrated skill and expertise beyond that which would normally be expected. It is important that all trusts set up advisory arrangements with majority professional input to ensure that all eligible associate specialists are reviewed annually.

There are no absolute requirements on trusts to award such discretionary points.

These are substantive payments and, therefore, pensionable.

### **On-Call**

Associate specialists are senior hospital doctors and should therefore occupy a senior position on the on-call rota. They are, however, responsible to a named consultant and should not be put in the position of taking ultimate responsibility for care of patients.

In view of the seniority of anaesthetists in this grade, no distinction should normally be made between the on-call duties of associate specialist and consultants. Any on-call undertaken by practitioners in the grade of associate specialist should be by agreement in their annual job plan and should be reflected in the allocation of notional half days. Particularly onerous workload may be recognised through the award of temporary additional notional half days, which are not superannuable.

All associate specialists should ensure that their workload, including on-call, is reviewed annually. Consideration should be given not only to the frequency of on-call but also to the intensity of that work. Particular care should be taken to ensure that the problems of the trainees are not, in their solution, merely transferred to other grades.

## **SECTION 8 - STAFF GRADE**

### **Introduction**

The staff grade is a permanent career grade of limited responsibility, introduced in 1988 as one of the measures to help resolve the problems of the hospital medical staffing career structure following the implementation of Achieving a Balance, Plan for Action [13].

A staff grade is accountable to a named consultant, normally the clinical director or head of department, but on a day to day basis to the duty consultant. There is no limit on the number of staff grade appointments that may be made nor is there any limit to the number of sessions worked and the contract can include an out of hours on-call commitment.

### **Qualifications**

Under national terms and conditions of service, a practitioner is eligible for appointment to the staff grade provided that the following criteria are met:

- (a) full registration with the General Medical Council;
- (b) a minimum of three years' full time hospital service in SHO or higher grades since first obtaining full or limited registration or equivalent;
- (c) a staff grade must provide proof of good health by passing a medical examination.

These are minimum requirements. In addition, and in view of the nature of the work undertaken by staff grade doctors, both the College and the Association require that all appointees would normally be expected to possess a postgraduate qualification. This requirement may be waived if, in the opinion of the College assessor, the applicant has completed a programme of training and gained sufficient relevant experience to fulfil the requirements of the job plan.

### **Appointment Procedures**

Recent changes in legislation mean that staff grade posts are no longer subject to manpower controls.

It is recommended that the job plan should be approved by the regional advisor of the Royal College of Anaesthetists prior to the advertisement.

Posts in this grade should be advertised in such a way that the candidate unable to work full time is able to apply for the post.

The Advisory Appointments Committee should comprise, as a minimum, the following:

- (a) a lay chairman appointed by the trust;
- (b) a consultant anaesthetist from outside the trust, approved by the Royal College;
- (c) a consultant anaesthetist (usually the clinical director) from the trust.

Following ratification of the appointment by the trust, there is normally a probationary period of one year at the end of which time, subject to approval, the post becomes permanent and subject to normal terms of notice.

### **Contractual Arrangements [2, 14, 15]**

The basic contract is a commitment of ten four-hour sessions per week (pro rata for part time appointments). In addition, particularly onerous workload, significant extra responsibilities or out of hours work may be recognised by extra sessions or part sessions paid pro rata to the basic salary.

Out of hours work can also be recognised within the basic ten sessions and not necessarily via additional sessions.

There is no limit to the number of sessions worked although it is recognised that it could be harmful to either doctors or patients for doctors to work an excessive number of hours.

There is a nine point salary scale divided between a number of automatic annual increments and a number of further optional points (five automatic increments (subject to starting salary) and four optional points).

### **Optional Points**

Optional points are consolidated payments paid in addition to the maximum point at the discretion of the employer. They are not seniority payments nor automatic annual increments. To warrant payment staff grade doctors will be expected to demonstrate skills and expertise beyond that normally expected of a doctor in that grade.

The key criteria for the award of optional points are clinical expertise and service to patients but account should be taken of overall workload and intensity. All staff grade doctors who are eligible to receive optional points should make a personal submission to the trust each year. The consultants responsible for the work of staff grade doctors will be required to give their written recommendations.

### **On-Call**

Advance letter (MD)4/97 notified employers of new arrangements for the employment of staff grade practitioners employed on national terms and conditions of service. This enabled staff grade doctors to take part in the on-call rota and for this commitment to be recognised in the job plan.

The BMA has issued extensive advice [15] on the implementation of advance letter (MD)4/97 and, in particular, the following should be noted:-

Where staff grade doctors are compulsorily resident on-call or work for the whole of the time that they are on duty out of hours, the allocation of sessions will be one session per four hours on-call.

Where staff grade doctors are required to work 50% or more of their time that they are on duty out of hours, the sessions will be allocated on the basis of one session per six hours on duty.

A lesser commitment should be reflected in the basis of sessional allocation. For example, 0-25% of time worked during the period of out of hours of duty should attract one session per eight hours of duty and 26-49% time worked should attract a sessional allocation of one session per seven hours of duty.

These are recommendations and should be the subject of agreement between the local negotiating committee and trust management.

All staff grades should ensure that their workload, including on-call, is reviewed annually. Consideration should be given not only to the frequency of on-call but also to the intensity of that work.

## **SECTION 9 - CLINICAL ASSISTANT**

### **Introduction**

The clinical assistant grade (previously known as part time medical officer) is most frequently held by doctors who are also general practitioners or who require limited sessional commitments because of other (usually domestic) responsibilities and who wish to maintain their clinical skills in a particular speciality.

Since the introduction of the staff grade, no clinical assistant appointments of more than five NHDs per week should have been made after January 1989, unless the appointee is an unrestricted principal in general practice (i.e. contracted to provide the full range of medical services). Those in post, at that date, with contracts of more than five NHDs were allowed to retain their appointment. In practice, this recommendation on maximum sessions has not been strictly adhered to.

Clinical assistants may be members of departments of anaesthesia in large hospitals but not infrequently are working alone in isolated units serving remote local communities and without immediate access to consultant support and supervision [16].

### **Qualifications**

There are no nationally agreed minimum qualifications or experience required for this grade in any designated speciality. However, the Association strongly recommends that doctors appointed to these posts should have:

- (a) a minimum of two years' whole time training in the speciality;
- (b) be in possession of the FRCA;
- (c) be able to demonstrate resuscitation skills in accordance with current UK Resuscitation Council guidelines.

### **Appointment procedures**

These posts may be advertised nationally but are often created as personal appointments to suit local needs and individual candidates. It is recommended that a formal interview procedure should take place in the presence of a senior manager of the trust, a consultant anaesthetist from the trust and one other senior hospital doctor.

### **Contractual agreements**

There is no nationally agreed contract for clinical assistants. Appointments are made under paragraph 94 of the terms and conditions of service document (April 1986 revised).

Remuneration is on a sessional basis and there is no provision for salary progression or professional career development within this grade.

The basis of the contract is the NHD of 3\_ hours worked flexibly and tenure is for one year with annual renewal which should only occur after a properly conducted annual review. If the post is no longer required, the incumbent may be eligible for redundancy payment under employment law.

There is no contractual entitlement to study leave or requirement for access to CME or CPD, although many trusts are and should be supportive of such requests [17].

### **On-Call Duties**

Except in isolated areas and exceptional circumstances, clinical assistants will not provide out of hours cover and will have clinical work confined to fixed daytime sessions. Any out of hours work should be remunerated for the period equated to NHDs.

The Association strongly recommends that those doctors currently holding clinical assistant appointments receive direct supervision and support from the local department of anaesthesia.

### **Recommendations**

The recommendations outlined in this advice apply to all non-consultant career grades including existing clinical assistants. The responsibility for maintaining clinical support and ensuring high standards of care cannot be ignored because of occasional geographical difficulties. Neither can the continuation of contracts of employment which do not provide the incumbent with employment benefits common in all other medical appointments or support the philosophy of CME and CPD be justified.

The Association recommends that no further clinical assistant appointments be made and that staff grade posts (with nationally agreed terms and conditions of service) be created in the future when the need arises. Where general practitioners wish to continue clinical sessions, the hospital practitioner grade would be a more appropriate appointment.

It is essential that College tutors, postgraduate deans and trust management support the need for continuing medical education by clinical assistants for both the benefit of the individual and as an intrinsic requirement of good practice and risk management.

## **SECTION 10 - HOSPITAL PRACTITIONER**

### **Introduction**

This grade is only open to principals in general practice and, at a national level, total numbers would seem to be declining [1] each year. This is probably a reflection of the increase in other areas of GP workload and may also be due to a reduction in numbers of anaesthetists who have undergone a substantial period of training and then leave anaesthesia to enter general practice.

### **Qualifications**

Appointment is limited to those principals who have been registered for a minimum of four years and have at least two years' whole time (or equivalent part time) experience in anaesthesia.

Although a postgraduate qualification is not a specific requirement for the grade, the Association supports the Royal College of Anaesthetists' recommendation [18] that possession of FRCA or equivalent is normally advisable.

Candidates should be competent in current resuscitation skills as stated in the UK Resuscitation Council guidelines.

### **Appointments**

These posts may arise as a result of individual local need and may be arranged locally or advertised nationally.

Suitably qualified candidates should be formally interviewed by a senior manager of the trust, a consultant anaesthetist and one other senior doctor.

It must be ensured that the appointment does not interfere with the principal duties of the GP to his/her practice and that hospital duties take priority during contracted sessions.

### **Contractual Arrangements [19, 20]**

The terms and conditions are stated in the relevant health circulars and the contract is based on NHDs to a maximum of five NHDs per week. The

appointment is renewable after one year, subject to confirmation, until the incumbent reaches retirement age [7] or ceases to be a principal in general practice.

This grade is responsible to a named consultant(s) and the Association recommends a minimum of two clinical sessions with appropriate time for pre-operative visits and postoperative care (three NHDs per week).

A provision for study leave is included in the contract of 30 days within a three year period and hospital practitioners would normally be expected to participate in clinical audit and departmental meetings.

Departments of anaesthesia and College tutors must encourage trusts to support applications from this grade to participate in CME.

### **On-Call Duties**

It is unlikely that holders of these posts will be involved in out of hours duties as they will also be participating in general practice emergency on-call rotas. Daytime fixed sessions may incorporate some emergency duties where required by negotiated agreement.

## **SECTION 11 - NON-STANDARD TRUST GRADES**

When the staff grade was established in 1989, numbers appointed were limited to 10% of consultant numbers and posts were intended to cover daytime service commitments and not to replace training grades in out of hours work.

In an attempt to circumvent these restrictions and provide for local medical staffing requirements, trusts established posts with contracts reflecting local needs rather than those based on the nationally agreed terms and conditions.

These non-standard appointments have various titles including trust doctor, trust specialist, staff specialist, trust anaesthetist, clinical specialist. The contracts usually incorporated out of hours work at a rate of remuneration defined by the trust and allowed appointment numbers to exceed the 10% limit.

The revised terms and conditions of service for staff grades and the ability to advertise for associate specialists have made such posts unnecessary. The Association of Anaesthetists strongly recommends that employers use this opportunity to offer existing non-standard grade doctors of the appropriate level the option to transfer to the new terms and conditions of service. Those doctors who fail to meet the standards set down in this advice should be offered the opportunity of retraining or professional development.

If, in exceptional circumstances, a trust or department of anaesthesia deems such a non-standard post to be necessary, it is recommended that potential applicants obtain advice from the BMA, the Association or the College tutor.

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