Northern Ireland Assembly

Research and Information Service Briefing Note

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Clinical Excellence Awards Schemes

1 Origins of the Schemes in the UK

There is no specific legislative context for the merit award schemes for consultants and clinical academics in the UK[1] however; they have been in existence since the introduction of the National Health Service in 1948. In May 1948 the Report of the Inter-Departmental Committee on the Remuneration of Consultants and Specialists (chaired by Sir Will Spens) was published. The Spens Report introduced the concept of a merit award system and advised the Government on the remuneration of specialists in the newly-formed NHS. It led to the introduction of **Distinction Awards** in 1949 and their inclusion into the terms and conditions of service for consultants at that time. In the Spens Report, the Committee recommended that three levels of award (A,B and C) be paid to recognise special contributions to medicine, exceptional ability

[1] Clinical Excellence Awards, DHSSPS, DH1/12/107162, Personal email communication from DHSSPS, 17th May 2012

or outstanding professional work.[2] The Committee noted that the pay arrangements should[3]:

- Limit the need of public service consultants to work in the private sector;
- Reach levels of pay equivalent to those in other professions; and
- Maintain the position of British medicine in a competitive international market.

The British Medical Association (BMA) continues to support these principles regarding the pay arrangements of consultants in the NHS and believes that:

> *"the recognition of the work of clinical academics and of the importance of supporting medical research are therefore, fundamental features of the schemes which the BMA believes are key both to their success and to the future of academic medicine".*[4]

2. The Subsequent Development of the Various UK Schemes

2.1 Introduction

Piecemeal changes to the original Distinction Award Scheme happened over subsequent decades and eventually led to the four separate but similar schemes that now exist in England and Wales, Scotland and Northern Ireland. Each scheme has a series of Lower Awards (considered by local employers) and a number of Higher Awards (considered by Committees established for the purpose in each jurisdiction). The submission made by the BMA to the current *UK Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Awards Schemes for NHS Consultants* (see Section 5 below for further details on this Review) outlines these separate schemes and the information in this section of the briefing is directly extracted and summarised from that submission with paragraph references as appropriate. The Scheme in place in Northern Ireland (NI) is introduced in this section but the detail for NI is covered in Section 3 of this briefing.

[2] Review of Compensation Levels, Incentives and the Clinical Excellence Award Schemes for NHS Consultants, DHSSPS Submission, December 2010, Sourced on Office of Manpower Economics website, http://www.ome.uk.com/Document/Default.aspx?DocumentUid=BD4886EB-030F-4B3A-919E-4E06E705AE10

[3] BMA Submission to the DDRB for its "Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants", BMA, November 2010, paragraphs 1.4-1.5, http://www.bma.org.uk/images/bmasubmissiontoddrbreviewceacompensationincentives_tcm41-207221.pdf

[4] BMA Submission to the DDRB for its "Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants", BMA, November 2010, paragraph 1.8 http://www.bma.org.uk/images/bmasubmissiontoddrbreviewceacompensationincentives_tcm41-207221.pdf

2.2 England and Wales

In addition to the Distinction Award Scheme, in 1995 the Department of Health introduced **Discretionary Points** to England and Wales as a way of recognising excellence at a local level. The same arrangements were also introduced in Scotland and Northern Ireland and the first such local awards were made in 1996.[5]

Almost a decade later, as part of the consultant contract negotiations which concluded in 2003/04, discussions took place on a replacement for the Distinction Award and Discretionary Point Schemes. This led to the introduction of the **Clinical Excellence Award (CEA) Scheme** for consultants and consultant clinical academics in **England and Wales**. In Wales a system of commitment awards was added to the pay-scale to replace the local employer-based awards but consultants remained eligible for national CEAs.[6] The CEA Framework was published in 2003[7] and the first awards were paid in 2004/05.

All Consultants with at least one year's service are eligible to apply and there are five domains in which applicants can detail their achievements: (1) delivering a high quality service; (2) developing a high quality service; (3) leadership and managing a high quality service; (4) research and innovation; and (5) teaching and training. National Awards are reviewed every five years and this process has also been introduced for local awards. If there is insufficient evidence of clinical contribution to make the award justifiable, it is withdrawn. A recent change to the scheme was the extension to senior academic GPs with honorary NHS contracts, thus enabling GPs in academia to have the potential to achieve earnings comparable to colleagues in the NHS.[8]

2.3 Scotland[9]

In 1998, Scottish Ministers decided to establish a **separate Scottish Advisory Committee on Distinction Awards (SACDA)**[10] to replace the existing Scottish Subcommittee of the UK committee and take responsibility for decisions on all consultants' Distinction Awards in Scotland. Improvements to the scheme have continued to be made since 1998, including its extension to senior academic GPs.

[5] BMA Submission to the DDRB for its "Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants", BMA, November 2010, paragraph 1.9 http://www.bma.org.uk/images/bmasubmissiontoddrbreviewceacompensationincentives_tcm41-207221.pdf

[6] BMA Submission to the DDRB for its "Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants", BMA, November 2010, paragraph 1.11 http://www.bma.org.uk/images/bmasubmissiontoddrbreviewceacompensationincentives_tcm41-207221.pdf

[7] The new NHS consultant reward scheme: Clinical Excellence Awards, Department of Health, August 2003 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084129

[8] BMA Submission to the DDRB for its "Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants", BMA, November 2010, paragraphs 1.13 – 1.22 http://www.bma.org.uk/images/bmasubmissiontoddrbreviewceacompensationincentives_tcm41-207221.pdf

[9] BMA Submission to the DDRB for its "Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants", BMA, November 2010, paragraphs 1.31 – 1.49 http://www.bma.org.uk/images/bmasubmissiontoddrbreviewceacompensationincentives_tcm41-207221.pdf

[10] SACDA – Scottish Advisory Committee on Distinction Awards, http://www.shsc.scot.nhs.uk/shsc/default.asp?p=71

Distinction Awards are centrally funded by the Scottish Government and the number of awards available for allocation each year is dependent upon the number of current award holders that retire and the number of new awards in line with consultant expansion. There are three levels of award (B, A, and A+), which are paid with salaries, are pensionable and subsume the value of any discretionary points or lower level distinction award previously held.

All applications for the Distinction Awards are assessed against the same criteria and scored by SACDA according to its Scoring Guidelines.[11] The criteria are as follows:

- Professional excellence and leadership;
- Research and service innovation;
- Management, administration and advisory activities;
- Contribution to clinical governance, audit and evidence based practice;
- Teaching and training; and
- Achievement of service goals.

All awards granted from the 1989 awards round onwards are subject to five-yearly review. The Discretionary Points Scheme (DP1 to DP8), which replaced the original C distinction award (referred to in Section 1), was introduced in 1996 to allow local NHS employers in Scotland to reward outstanding contributions to local patient care. NHS Boards award a minimum number of discretionary points based on the number of eligible consultants they employ (0.35 points per eligible consultant).

During the negotiations on a new consultant contract for Scotland it was agreed that a fundamental review should be undertaken of the Distinction Awards and Discretionary Points schemes in Scotland. This Review began in 2006 and the proposed new Scheme for Scotland - ***Scottish Consultants Clinical Leadership and Excellence Awards Scheme (SCCLEA)*** comprises 13 continuous points – 1-10 to be administered by NHS Scotland boards and 11-13 to be the responsibility of the Scottish Advisory Committee on Consultants' Clinical Leadership and Excellence Awards (SACCCLEA), which will replace SACDA.

The domains under which consultants will be able to outline achievements are: (1) Scope and Level of Professional Contribution to NHS; (2) Audit, Clinical Governance, Promotion of Evidence Based Medicine; (3) Administrative, Management and Advisory Activities; (4) Research and Innovation; (5) Teaching and Training; and (6) Improvements in Service and Achievement of Service Goals.

The Cabinet Secretary for Health and Wellbeing announced (in November 2010) a freeze of the existing Distinction Awards and Discretionary Points schemes by allowing no new awards and no increase in their value for 2011-12 to free up resources which could be redirected to front-line patient care. As a consequence, it was also decided

[11] SACDA – Scottish Advisory Committee on Distinction Awards, http://www.shsc.scot.nhs.uk/shsc/default.asp?p=71

that it would not be practical yet to introduce the new SCCLEA scheme. According to the SACDA website, the 2012/13 Five Yearly Reviews will take place as usual.[12]

2.4 Northern Ireland

The current consultant contract was introduced in NI in 2004 and this was followed by the introduction of the **Northern Ireland Clinical Excellence Awards Scheme** in 2005. The NI Scheme is largely modelled on the Scheme for England, but with some differences. The details for NI are found in Section 3 below.

3. The Northern Ireland Clinical Excellence Scheme

3.1 Introduction

The **NI CEA** was introduced in 2005 and is operated by HSC employers (For Lower Awards) and by the DHSSPS (for Higher Awards). At present, for Lower Awards employers are required to allocate a minimum of 0.25 awards per eligible consultant, "*this is the least generous scheme in the UK with other jurisdictions operating a 0.35 formula to make awards*".[13] According to the BMA, it was initially poorly funded with new awards being distributed after previous award holders had retired. During the period 2005-2008, this created a ratio of receipt of new awards to eligible consultants which compared unfavourably with the rest of the UK. With an expansion in the number of consultants across NI, this meant any funding was spread even more thinly.

In 2008, the DHSSPS commenced a review of the NI CEA scheme which particularly focussed on the funding of the CEA scheme. The Review Group produced a report recommending:

- A reduction in the ratio of awards to eligible holders to 0.25 (the current position);
- Moving the Step 9 award from local distribution to regional distribution by the Northern Ireland Clinical Excellence Awards Committee (NICEAC);
- Preventing eligible consultants from applying for both a higher and a lower CEA in the same year (this restriction does not exist elsewhere in the UK).

As at 31st December 2011, there were 1,466 (1,380.6 whole-time equivalent) consultants working in NI HSC organisations. Of these, 159 (11.69%) were on the maximum basic salary point of £100,446. The most recent awards round took place in 2009/10 as reported in the Northern Ireland Clinical Excellence Awards Committee Annual Report 2009/10 and the total number of award holders at that time was 686.[14]

[12] SACDA – Scottish Advisory Committee on Distinction Awards, http://www.shsc.scot.nhs.uk/shsc/default.asp?p=71
[13] Clinical Excellence Awards, DHSSPS, DH1/12/107162, Personal email communication from DHSSPS, 17th May 2012
[14] Letter dated 5th March 2012 to Committee for HSSPS from the Minister for HSSPS, COR/147/2012

3.2 The NI CEA Scheme Details

The information in this section is directly extracted and summarised from Guide to the *Northern Ireland Clinical Excellence Awards Scheme, 2010/2011 Awards Round*, DHSSPS, May 2010[15], with paragraphs referenced as appropriate. This Guide provides detailed guidance on the scheme and covers both Higher Awards (decided by the NI Clinical Excellence Awards Committee) and Lower Awards (decided by HSC Trusts). The awards are given to recognise and reward contributions to HSC which are "over and above" the standard normally expected of a consultant in their post.

3.2.1 Objectives of Scheme

The objectives of the Scheme are to reward individuals who perform over and above the standard expected of a consultant in their post, and who locally, regionally, nationally or internationally[16]:

Demonstrate sustained commitment to patient care and wellbeing or improving public health;

Sustain the highest standards in both technical and clinical aspects of service delivery whilst providing patient focused care;

In their day to day practice demonstrate a sustained commitment to the values and goals of HSC by participating actively in annual job planning, observing the private practice Code of Conduct, and showing a commitment to achieving agreed service objectives;

Through active participation in clinical governance contribute to continuous improvement in service organisation and delivery;

Embrace the principles of evidence-based practice;

Contribute to the knowledge base through research or other scholarly work and participate actively in research governance;

Are recognised as exceptional teachers and/or trainers and/or managers;

Contribute to policy-making and planning in health and health care;

Make an outstanding contribution to professional leadership.

[15] *Guide to the Northern Ireland Clinical Excellence Awards Scheme, 2010/2011 Awards Round*, DHSSPS, May 2010, http://www.dhsspsni.gov.uk/dh1_10_65659.pdf

[16] *Guide to the Northern Ireland Clinical Excellence Awards Scheme, 2010/2011 Awards Round*, DHSSPS, May 2010, paragraph 3, http://www.dhsspsni.gov.uk/dh1_10_65659.pdf

3.2.2 Structure of Scheme – Levels of Awards

The **Northern Ireland Clinical Excellence Awards scheme** is a single, graduated scheme and comprises both local and regional elements. **Lower Awards** (formerly called Discretionary Points) will be made by local (employer) committees. These awards primarily reward outstanding contributions to local service delivery priorities. **Higher Awards** (formerly Distinction Awards) are recommended by **the Northern Ireland Clinical Excellence Awards Committee (NICEAC)** and contributions at a regional, national and international level are important. However, it is possible for consultants who deliver a wholly local contribution to progress to the Higher Awards.[17]

NICEAC is a Non-Departmental Public Body appointed under Article 25 of the HPSS (NI) Order 1972 (Advisory Committees). Its function is to make recommendations to the DHSSPS on which HSC consultants should receive the higher value awards, having regard to the number of awards available for allocation. It also has a quality assurance role over the local awards process. The membership is: Lay Chairman; Vice Chairman (Medical Director); two HPSS Medical or Dental members; two External medical members (GB); two Employer members and one Lay member. NICEAC has a secretariat that forms part of the DHSSPS.[18]

There are twelve levels of award. The first eight awards are recommended by local committees (steps 1- 8), and the four highest awards are recommended by NICEAC (steps 9 -12) (All awards are decided on the grounds of merit).[19]

There is a single set of assessment criteria, with one standard CV self-nomination form for all levels of awards. There is a standard process for seeking citations at both levels.[20] The assessment criteria are outlined in detail in paragraphs 48 – 68 of the DHSSPS guidance, the criteria headings are:

- Delivering a high quality service;
- Developing a high quality service;
- Managing a high quality service;
- Teaching and training; and
- Research.

Awards are paid in addition to the consultant's basic salary; Higher Awards then subsume the value of any award held previously; and awards for part time consultants will be paid on a pro rata basis (excluding Joint Appointments). The values of all awards are normally determined in accordance with the recommendations of the Doctors and Dentists Pay Review Body (DDRB).[21]

[17] Paragraph 5 of DHSSPS Guidance (see footnote 15)
[18] Paragraphs 12-17 of DHSSPS Guidance (see footnote 15)
[19] Paragraph 6 of DHSSPS Guidance (see footnote 15)
[20] Paragraph 7 of DHSSPS Guidance (see footnote 15)
[21] Paragraph 8 of DHSSPS Guidance (see footnote 15)

The number of awards available each year is limited. For Lower Awards, employers are required to allocate a minimum of 0.25 awards per eligible consultant. The DHSSPS determines the number of higher awards available for allocation, taking into account any recommendations of the DDRB.[22]

Consultants already in receipt of a Distinction Award or Discretionary Points keep them, (subject to review), and are eligible to apply for awards under the Clinical Excellence Awards scheme. An award of a CEA then subsumes the value of any Discretionary Points or Distinction Awards held by the consultant.[23]

3.2.3 Eligibility for an Award

Those eligible for a Clinical Excellence Award are[24]:

- Consultants who have at least three years' experience at consultant level (in England, it is one year's experience to be able to apply);
- Joint Appointees – the entitlement to full eligibility for an award is based on five programmed activities (or equivalent sessional time) beneficial to the HSC, including teaching and clinical research;
- Eligible consultants who are subsequently employed as Deans (undergraduate and postgraduate) in medicine or dentistry are fully eligible on the basis of their work in such posts;
- Eligible consultants working as clinical and medical directors of HSC Trusts retain their eligibility for clinical excellence awards, account being taken of both their clinical work and their contribution as clinical or medical director.

For Higher Awards, consultants must have achieved a minimum of four lower Clinical Excellence Awards or four Discretionary Points to become eligible. NICEAC consider that in most cases it would normally take at least 10 years for consultants applying for a step 9 award, to accumulate the quantity and quality of evidence that would be necessary in order to justify an award. Consultants are not allowed to apply for both a Lower and a Higher Award in the same year. Eligibility for all awards is dependent upon participation in annual appraisal and a satisfactory appraisal must have taken place in the 12 months prior to the application.[25]

3.2.4 Review of Awards

Clinical Excellence Awards and Distinction Awards (granted from the 1989 awards round onwards) are both subject to review at five-yearly intervals.[26] Consultants, applying for a five year review only, must set out how they continue to meet the criteria for an award. They should demonstrate that the work done since the original award or

[22] Paragraph 9 of DHSSPS Guidance (see footnote 15)
[23] Paragraph 11 of DHSSPS Guidance (see footnote 15)
[24] Paragraph 18 of DHSSPS Guidance (see footnote 15)
[25] Paragraphs 19-22 of DHSSPS Guidance (see footnote 15)
[26] Paragraphs 69-81 of DHSSPS Guidance (see footnote 15)

the last review continues at a standard to justify the level of the award that is currently held.

In the case of a Higher Award, if the Committee concludes that an award is no longer merited it will recommend that the award should be withdrawn or downgraded. Before this recommendation is implemented, the consultant has the opportunity to make a written submission to NICEAC before the final decision is taken. In some circumstances, the Committee may recommend that a consultant's award be renewed for a shorter period than 5 years, thus allowing the consultant an opportunity to demonstrate that he or she once again meets the criteria for the level of award held.

A system of salary protection will generally be applied if an award is downgraded or withdrawn. The consultant's salary will be frozen until the maximum of the consultant salary scale (plus the value of any lower award if the original award was downgraded) has caught up with his or her 'mark-time' earnings. In exceptional circumstances NICEAC may determine that an award be withdrawn completely.

On retirement, all awards cease; they are consolidated into pension and consultants who are re-employed after retirement do not retain eligibility for payment of their award.[27]

3.2.5 Current Situation in Northern Ireland

The NI CEA scheme differs in some respects to the awards schemes in the other devolved administrations. In NI application is by self-nomination only and there are different rules on eligibility and with the process for seeking citations. There is also a single set of assessment criteria which applies to all levels of award. Additionally, for the Lower Awards employers are required to allocate a minimum of 0.25 awards per eligible consultant compared to the 0.35 formula used in other areas of the UK.[28]

In the context of various factors such as the Government's two-year pay freeze, the budget pressures arising from the Comprehensive Spending Review and in light of the UK-wide Review of Clinical Excellence Award Schemes (see section 5 below for further detail), the DHSSPS consulted on two options for the 2010-2011 award round - Option 1 - Allocate new CEAs in the normal manner or Option 2 - Allocate no new CEAs in the 2010/11 year. The consultation closed on 22nd April 2011.[29]

The Department took Option 2 but recognised the strong support that exists, from within the profession, for the CEA scheme to continue, however, the predominating factor the DHSSP considered was the supplementary guidance from DFP to Departments on the implications of the public sector pay freeze. This guidance stated

[27] Paragraph 30 of DHSSPS Guidance (see footnote 15)

[28] Review of Compensation Levels, Incentives and the Clinical Excellence Award Schemes for NHS Consultants, DHSSPS, December 2010, paragraph 9, http://www.ome.uk.com/Document/Default.aspx?DocumentUid=BD4886EB-030F-4B3A-919E-4E06E705AE10

[29] Consultation on the Northern Ireland Clinical Excellence Awards Scheme 2010-2011, DHSSPS, http://www.dhsspsni.gov.uk/consultation_paper_on_2010-2011_awards_round

that where no legally binding agreement has been entered into the pay freeze should apply to all public sector staff groups. The DHSSPS stated that CEAs are recurrent pensionable payments and the Review Body on Doctors' and Dentists' Remuneration (DDRB) recognises that these awards are one of the five elements making up consultants pay.[30]

The Minister confirmed to the Committee in a letter dated 5th March 2012, that for the period of the public sector pay freeze, which for CEAs covers the financial years 2010/11 and 2011/12 no new awards are planned and he is considering the DHSSPS position on the way forward for 2012/13 and beyond.[31] Once awarded, a CEA effectively becomes part of a doctor's terms and conditions and, if removed, could constitute an unlawful deduction of earnings.[32]

The BMA have highlighted that the cessation of the CEA scheme follows on from previous poor funding of the scheme and has led to a "*severe demoralizing effect on Northern Ireland Consultants, particularly after the renewed interest in the scheme with the improved funding after the 2008 review*".[33]

The BMA(NI) has been pursuing the reinstatement of CEAs since the announcement to suspend the awards was made in 2010 and subsequent legal action was taken.[34] In response to the case brought by the BMA(NI), consideration for an application for leave was given on 23rd January 2012 and the case was heard on 10th and 11th May 2012.

The case was adjourned until 8th June to "*resolve the question of the failure of the Department to release the DDRB Review Report - which the BMA(NI) believes to be a material factor in the Department's decision to suspend CEAs.*" The hearing took place on 8th June and a final judgment is expected on 9th November 2012 on whether a CEA is a component of remuneration.[35]

The cost of Higher Awards falls to the DHSSPS to fund and administer. In 2009/10 the budget was £5.8 million and had been at that level for a number of years. The scheme operates by recycling the value of awards which cease on retirement or review. As an awards round has not been run in 2010/11 or 2011/12, the budget for Higher Awards now stands at £4.3 million.[36]

[30] CONSULTATION ON THE CLINICAL EXCELLENCE AWARDS SCHEME Consultation Results and Departmental Response http://www.dhsspsni.gov.uk/public_consultation_results_departmental_response_september_2011.pdf
[31] Letter dated 5th March 2012 to Committee for HSSPS from the Minister for HSSPS, COR/147/2012
[32] Letter to Committee for HSSPS, from Minister for HSSPS, Reference - COR/1952/2011, DHSSPS, 30/01/2012
[33] BMA Submission to the DDRB for its "Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants", BMA, November 2010, paragraph 1.59-1.60 http://www.bma.org.uk/images/bmasubmissiontoddrbreviewceacompensationincentives_tcm41-207221.pdf
[34] Letter to Committee for HSSPS, from Minister for HSSPS, Reference - COR/1952/2011, DHSSPS, 30/01/2012
[35] Personal Email Communication with Assembly and Research Officer at BMA (NI), 3/10/12
[36] Clinical Excellence Awards, DHSSPS, DH1/12/107162, Personal email communication from DHSSPS, 17th May 2012

4. Comparison of Value of Awards across the UK

The value of award steps paid in Northern Ireland is identical to those paid in England. The Lower Awards paid in Scotland and Wales are identical in value, but the Higher Awards are different. The levels and values of the awards in each jurisdiction are as follows[37]:

Table 1 Value of Award Steps Across the UK

Northern Ireland		Scotland		England		Wales	
Award	**Value**	**Award**	**Value**	**Award**	**Value**	**Award**	**Value**
Step 1	£2,957	DP 1	£3,204	Level 1	£2,957	DP 1	£3,204
Step 2	£5,914	DP 2	£6,408	Level 2	£5,914	DP 2	£6,408
Step 3	£8,871	DP 3	£9,612	Level 3	£8,871	DP 3	£9,612
Step 4	£11,828	DP 4	£12,816	Level 4	£11,828	DP 4	£12,816
Step 5	£14,785	DP 5	£16,020	Level 5	£14,785	DP 5	£16,020
Step 6	£17,742	DP 6	£19,224	Level 6	£17,742	DP 6	£19,224
Step 7	£23,656	DP 7	£22,428	Level 7	£23,656	DP 7	£22,428
Step 8	£29,570	DP 8	£25,632	Level 8	£29,570	DP 9	£25,632
Step 9	£35,484			Level 9 / Bronze	£35,484	Bronze	£35,484
Step 10	£46,644	B Award	£31,959	Silver	£46,644	Silver	£46,644
Step 11	£58,305	A Award	£55,924	Gold	£58,305	Gold	£58,305
Step 12	£75,796	A+ Award	£75, 889	Platinum	£75,796	Platinum	£75,796

Although the top national awards are of considerable monetary value; the majority of awards are given at the lower end of the scale. For example in England 0.53% of the consultant population were in receipt of a Platinum award and towards the other end of the scale 4.96% of the consultant population were in receipt of a Level 4 award.[38]

In NI in the 2009/10 award rounds, a total of 142 Lower Awards were made to 134 consultants, this is a decrease on the previous year when 176 Lower Awards were made. Only the Western HSC Trust met the minimum number of awards required (0.25 awards per eligible consultant). The Belfast HSC Trust funded awards based on limits of available funding (55 awards of 96 required), the South Eastern HSC Trust reported that a number of applications failed due to poor submissions by applicants (25 awards of 31 required), the Northern HSC Trust reported lower number of applicants

[37] Clinical Excellence Awards, DHSSPS, DH1/12/107162, Personal email communication from DHSSPS, 17th May 2012

[38] BMA Submission to the DDRB for its "Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants", BMA, November 2010, paragraph 1.25, http://www.bma.org.uk/images/bmasubmissiontoddrbreviewceacompensationincentives_tcm41-207221.pdf

than possible awards (26 out of 31, made 17 awards from the 26), the Southern HSC Trust recycled awards only due to financial situation (16 awards of 28 required).[39]

With regard to Higher Awards, in NI 15 awards were available for allocation in the 2009/10 award round and there were 79 applications.[40] As an indication, in 2010/11, figures show that 99 consultants[41] were in receipt of an existing Higher Award and 16 consultants were in receipt of an existing Higher Award in excess of £50,000.[42]

5. The UK Review of Compensation Levels, Incentives and the Clinical Excellence Award Schemes for NHS Consultants

At the request of the four UK Health Departments, the Review Body on Doctors' and Dentists' Remuneration (DDRB) is carrying out an independent review looking at compensation levels and incentive systems and the various Clinical Excellence and Distinction Award Schemes for NHS consultants at both national and local level in England, Wales, Scotland and Northern Ireland. The DDRB had to submit its recommendation to UK Ministers by July 2011. The Office of Manpower Economics (OME) has confirmed that the Review is not yet published and the current position on publication remains as stated on the OME website and is unchanged since July 2011, as follows:

"*UPDATE - JULY 2011*

The Review Body has today (7 July 2011) submitted its report to Ministers. The decision on when to publish the report now rests with Ministers. When the report is published, it will also be made available here on the OME website."[43]

The remit of the Review was to[44]:

- "To consider the need for compensation levels above the basic pay scales for *NHS consultant doctors and dentists including clinical academics with honorary NHS contracts, in order to recruit, retain and motivate the necessary supply of consultants in the context of the international medical job market and maintain a comprehensive and universal provision of consultants across the NHS. The review will consider total compensation levels for consultants and may make observations (rather than recommendations) on basic pay scales;*

[39] NI CEA Committee Annual Report 2009/10, DHSSPS, page 13
[40] NI CEA Committee Annual Report 2009/10, DHSSPS, page 3
[41] 34 of the 99 consultants were in receipt of an A+, A, or B from the original scheme prior to the NI CEA scheme, 13 retired during 2010/11
[42] Letter to Committee for HSSPS, from Minister for HSSPS, Reference - COR/1952/2011, DHSSPS, 30/01/2012
[43] Personal Email Communication from the Review Body on Doctors' and Dentists' Remuneration, Office of Manpower Economics, 8th October 2012
[44] Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants, Office of Manpower Economics, http://www.ome.uk.com/DDRB_CEA_review.aspx

- *To consider the need for incentives to encourage and reward excellent quality of care, innovation, leadership, health research, productivity and contributions to the wider NHS - including those beyond the immediate workplace, and over and above contractual expectations. The review should specifically reassess the structure of and purpose for the Clinical Excellence and Distinction Awards Schemes and provide assurance that any system for the future includes a process which is fair, equitable and provides value for money*".

In order to gain an insight into the views of the DHSSPS, the Northern Ireland Clinical Excellence Awards Committee (NICEAC) and the BMA as regards the future of the merit award schemes, the main points made by these organisations in submissions to the Review are included below (paragraphs in the relevant submissions referenced as appropriate).

DHSSPS

It is the DHSSPS view that the DDRB Review provides an opportunity to reassess the structure and purpose of the current schemes to ensure that whatever system is in place is fair, equitable and provides value for money.

The DHSSPS believes that the prospect of a Clinical Excellence Award is not the main reason why an individual would wish to enter the consultant grade in NI as the total remuneration received by a consultant can be substantially increased by, for example, working additional programmed activities, waiting list initiatives or by private practice. However, the DHSSPS highlights that it is vitally important to retain pay parity with the rest of the UK. With regard to recruitment from the international medical market the DHSSPS feels it is unlikely that most doctors are going to be significantly influenced by the Clinical Excellence Awards scheme.[45]

It is the DHSSPS view that the current award system is one of the motivating factors for consultants to show sustained commitment to achieving the delivery of high quality care to patients and to continuous improvement. The DHSSPS recognises that many consultants undertake work that is far beyond their contracted obligations and believe that some form of award system should be in place to reward them for this.[46]

Whilst the DHSSPS believes that an award system should be maintained, it questioned whether the current system truly reflects excellence, as in NI 52% of all eligible consultants held a Clinical Excellence Award at 1 April 2010. The DHSSPS question whether such a high percentage of any other profession could be deemed to be producing exceptional personal contributions over and above what was expected from them.[47]

[45] Review of Compensation Levels, Incentives and the Clinical Excellence Award Schemes for NHS Consultants, DHSSPS Submission to DDRB Review, December 2010, paragraphs 14-15, http://www.ome.uk.com/Document/Default.aspx?DocumentUid=BD4886EB-030F-4B3A-919E-4E06E705AE10

[46] DHSSPS Submission to DDRB Review, paragraph 19 (see footnote 45 for full reference)

[47] DHSSPS Submission to DDRB Review, paragraphs 21 and 27 (see footnote 45 for full reference)

The DHSSPS highlighted a variety of reasons for reviewing the current award schemes - at a time of financial stringency it is difficult to justify the current financial benefits of a scheme to a group of public sector workers who already receive very generous remuneration; and the fact that awards are paid in addition to basic salary, are recurrent, consolidated for pension purposes and awarded for life subject to a five year review process, has led DHSSPS to the conclusion that the current system is no longer fit for purpose.[48]

In recent years Trusts have found it difficult to fund the Lower Awards and some can only fund them by recycling awards from staff that have retired or left and this has led to increased variability across the HSC in terms of the number of lower awards being made. It is the DHSSPS view that the award system must be equitable across HSC Trusts in Northern Ireland.[49]

According to the DHSSPS, one of the main criticisms of the scheme in is in terms of objectivity and fairness - women are under represented amongst Higher Award holders whilst 72% of Higher Award holders come from the Belfast HSC Trust.[50]

The DHSSPS believes that any new arrangements should be based on a set of principles that apply across the UK to ensure that none of the four countries will be disadvantaged when recruiting, and that consultants will have the same opportunity for reward irrespective of where they choose to work; the assessment criteria for local and regional awards should be the same; and there should be nationally agreed scoring frameworks that apply to both local and regional awards.

The DHSSPS suggested that the DDRB consider recommending that any future Awards are made on a one-off basis and not consolidated for pension purposes to ease cost pressures from the scheme.[51]

NICEAC

NICEAC believes that a reward system is required in order to reward excellent quality of care, innovation, leadership, health research, productivity and contributions to the wider NHS including the following reasons:

- **Encouraging Long term excellence -** It is the NICEAC view that in order to encourage excellence in the long term, a higher level reward scheme is required;
- **Recognition –** The recognition that comes with an award is often at least as important as the financial gain;

[48] DHSSPS Submission to DDRB Review, paragraphs 22 and 23 (see footnote 45 for full reference)
[49] DHSSPS Submission to DDRB Review, paragraph 24 (see footnote 45 for full reference)
[50] DHSSPS Submission to DDRB Review, paragraph 27 (see footnote 45 for full reference)
[51] DHSSPS Submission to DDRB Review, paragraph 40 -41 (see footnote 45 for full reference)

- **Comparability –** It seems inherently fair to reward good performance as opposed to just paying a basic salary. Other professional groups are rewarded for exceptional work;
- **Retention -** Many consultants already work "over and above" their contractual commitments. In order to ensure that that these consultants are not lost to the health service, overseas or to other professions, it is vital that there are appropriate methods of reinforcing such positive behaviours formally; and
- **Quality -** The current consultant's contract recognises the quantity of work done rather than the quality. Financial reward can be therefore be achieved regardless of the quality of the outcome.

Whilst NICEAC believes that some form of reward system should exist, it acknowledges that the DDRB review provides an ideal opportunity to assess the most appropriate way of incentivising excellence. NICEAC believe one of the weaknesses of the current scheme is the inequality in the allocation of awards throughout the UK. In NI there has been a particular problem in that the number of awards at the lower level has been much smaller over a number of years than for the corresponding awards in other parts of the UK. This has also caused problems of progression and the awards scheme at local and regional level is intended to be a seamless progression.

NICEAC also highlighted that the DDRB should consider the number and value of awards allocated to determine whether the current systems deliver value for money and that the current system is labour intensive both for committees and applicants. In NI self-nomination is the only way of making an application for a Higher Award and can result in an unrealistically high number of applications for the very small number of awards that is normally available.

BMA

In its submission to the DDRB, the BMA highlighted two main messages. Firstly, that lack of recognition of excellent work through reward schemes was likely to result in consultants concentrating primarily or solely on core responsibilities, for example, they would be less likely to take on additional unpaid work such as research, leadership roles, committees and local service development. Secondly, there is concern that major changes to merit award schemes may result in a two tier consultant system where more established consultants and clinical academics have benefited from merit awards and newer consultants will not.[52]

The BMA believes that:

[52] BMA Submission to the DDRB for its "Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants", BMA, November 2010, paragraphs 1.114-1.115 http://www.bma.org.uk/images/bmasubmissiontoddrbreviewceacompensationincentives_tcm41-207221.pdf

> *"merit award schemes help retain and recruit excellent staff in what in many areas is an international market, as the Spens report itself acknowledged. They also provide incentives for new and excellent work; encourage dedication to a highly valued public service; and maintain consistent levels of excellence in all parts of the UK. While no consultant embarks on a service or practice-improving project solely because of the potential to receive an award, there is no doubt that it helps to compensate for and recognise the extra work this demands".*[53]

Among many examples, the BMA highlighted the routine good survival of 28 week old babies; the successful treatment of infertility; the safe trials and widespread use of drugs for heart disease; the effective treatment of AIDS; and the massive improvements in anaesthetics - all developments led by consultants in secondary care, participating in trials and sharing their findings and knowledge.[54]

[53] BMA Submission to DDRB, paragraph 1.121 (see footnote 52 for full reference)
[54] BMA Submission to DDRB, paragraph 1.1.122 (see footnote 52 for full reference)