

Review Body on Doctors' and Dentists' Remuneration

Review of compensation levels, incentives
and the Clinical Excellence and Distinction
Award schemes for NHS consultants

Chairman: Ron Amy, OBE



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incentives and the Clinical
Excellence and Distinction Award
schemes for NHS consultants

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**Presented to Parliament by the
Prime Minister and the Secretary of State for Health
by Command of Her Majesty**

**Presented to the Scottish Parliament by the
First Minister and the Cabinet Secretary for Health and Wellbeing**

**Presented to the National Assembly for Wales by the
First Minister and the Minister for Health and Social Services**

**Presented to the Northern Ireland Assembly by the First Minister,
Deputy First Minister and Minister for Health, Social Services
and Public Safety**

December 2012

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Review Body on Doctors' and Dentists' Remuneration

The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971. The terms of reference for the Review Body were introduced in 1998, and amended in 2003 and 2007. They are reproduced below:

The Review Body on Doctors' and Dentists' Remuneration is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Wellbeing of the Scottish Parliament, the First Minister and the Minister for Health and Social Services in the Welsh Assembly Government and the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive on the remuneration of doctors and dentists taking any part in the National Health Service.

In reaching its recommendations, the Review Body is to have regard to the following considerations:

the need to recruit, retain and motivate doctors and dentists;

regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists;

the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits;

the Government's inflation target;

the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

The Review Body may also be asked to consider other specific issues.

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, staff and professional representatives and others.

The Review Body should also take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability.

Reports and recommendations should be submitted jointly to the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Wellbeing of the Scottish Parliament, the First Minister and the Minister for Health and Social Services of the Welsh Assembly Government, the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive and the Prime Minister.

The Review Body was provided with the following terms of reference for carrying out this review:

The review is to look 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 review will take place in the context of key Government documents and the remit is:

- 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.
- 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.

The review will be fully linked into other activity on public sector pay including:

- The benchmarking work on senior public sector pay being carried out by the Senior Salaries Review Body;
- The Fair Pay Review in the public sector led by Will Hutton; and
- The review of public service pensions by the Independent Public Service Pensions Committee chaired by John Hutton.

The review should consider issues of comparability with other public sector and NHS incentive schemes. The recommendations of the review must take full account of affordability and value for money. The recommendations must also respect the accrued rights of individuals.

The review is to be led by the Review Body on Doctors' and Dentists' Remuneration (DDRDB). The DDRDB as an independent body will work closely with a range of external stakeholders, including NHS Employers, the British Medical Association and the independent Committees which make awards in the four countries.

The review has been commissioned by Ministers of the four countries in the UK.

The DDRDB has been asked to submit recommendations to UK Ministers by July 2011.

The members of the Review Body are:

Ron Amy, OBE (*Chairman*)

John Glennie, OBE

Sally Smedley

Professor Ian Walker

Katrina Easterling

David Grafton

Professor Steve Thompson

David Williamson

The Secretariat is provided by the Office of Manpower Economics.

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SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Overview

The consultant body is comprised of the most senior medical and dental staff in the NHS, who have expert knowledge of their specialties. Working either independently or as part of a team, they lead the delivery of NHS services. The recruitment, retention and motivation of consultants is vital to the effective and safe delivery of NHS services, and we believe that the pay structure should reflect this imperative.

We have assessed the pay position of consultants relative to comparator professions, and conclude that the overall level of compensation for consultants is appropriate. We recognise that the awards – which comprise a small element of the consultant pay bill – are perceived by the medical profession as having a strong influence on recruitment and retention, and provide both an incentive to work beyond the job role and recognition for doing so. We believe that variable award schemes continue to be required to reward, recognise and provide incentives for those consultants who go significantly beyond expectations, both in terms of providing a service to patients, and in contributing to the development of the NHS as a whole, through research, teaching, professional development or developing innovative practice.

However, we have reservations about the existing schemes: they are consolidated into basic pay, are pensionable, are held until retirement and are treated, to all intents and purposes, as an extension to the basic pay scale. In our view, awards should not be a substitute for pay progression; we outline below our proposed integrated package and career structure for consultants.

We believe that there should be a much stronger link between local awards and the performance appraisals of consultants. Awards should be made to the highest performing consultants in each employing organisation, and there is a strong argument for the awards to be one-off annual lump-sum payments. While we are content for local employers to have discretion over decisions about local schemes, we recommend that such schemes should operate within a United Kingdom-wide framework of common principles and governance.

The contribution that consultants make to the NHS, that has an impact beyond their employing organisation, is vital: national awards should continue to recognise those consultants with the greatest sustained levels of performance and commitment to the NHS and whose achievements are of national or international significance. We believe that national awards should be held for a period to be decided by the awarding body, but with an absolute maximum of five years. Award holders should be free to apply for a new award at any time in the same pool as all other applicants.

Since local and national award schemes have different objectives, it seems logical that a high-performing consultant could hold both local and national awards simultaneously.

Because we recommend that payments made under any new award scheme, at a local or national level, should be non-consolidated and non-recurrent, we think it is no longer appropriate for the awards to be pensionable. We also believe that existing awards should become non-pensionable for future service.

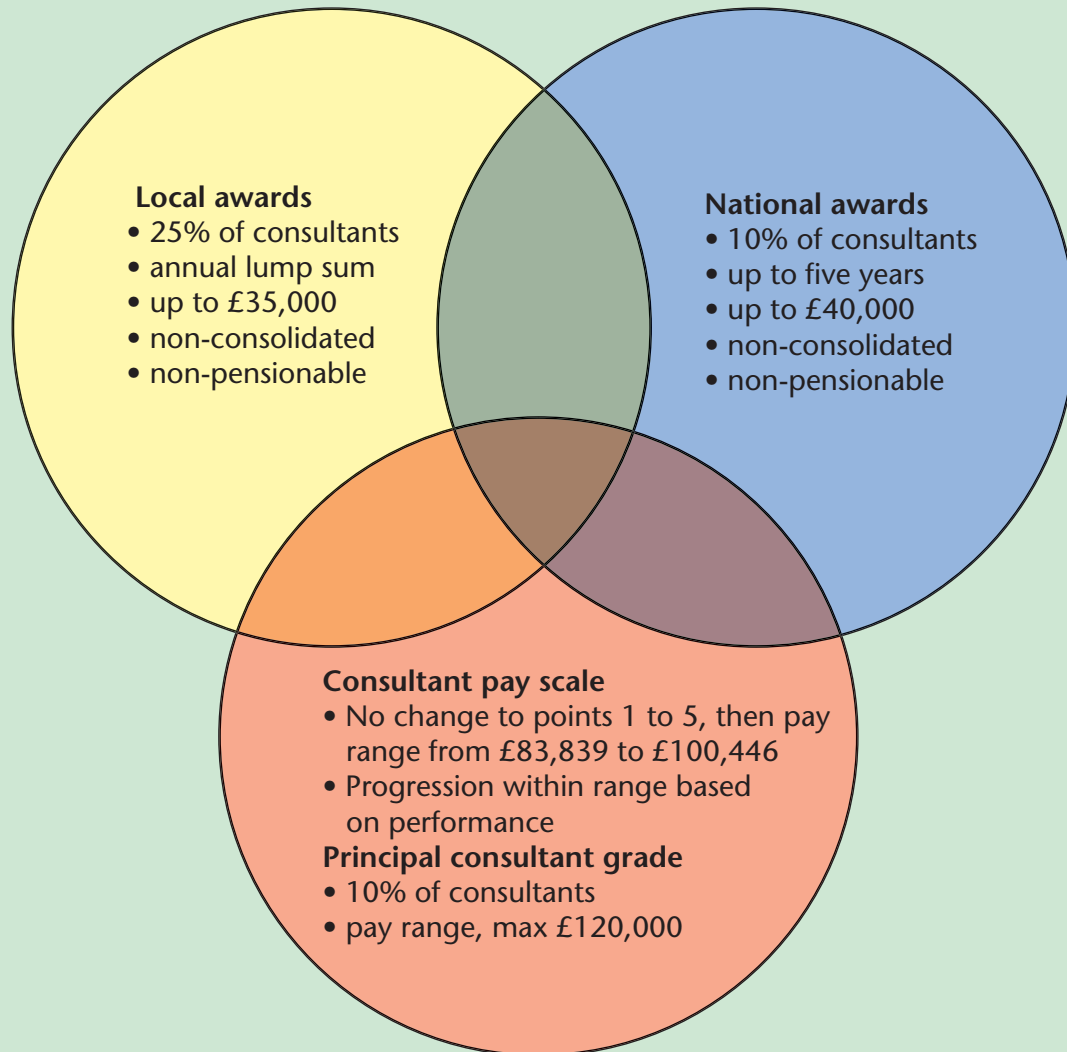
We would like to see the new schemes for national and local awards introduced at the earliest opportunity, following appropriate consultation. Existing award holders should be encouraged to move to the new schemes, as we think it is counter-productive to have legacy schemes that continue for a long time. Our intention is that award holders should not be able to hold awards simultaneously on the old and the new schemes, and that in accepting an award under the new schemes an individual would relinquish any awards under the current or previous schemes. We recognise that individuals have accrued rights under the current and previous schemes and we consider that it is for the parties to agree the substance of these accrued rights.

We have made a number of observations on the basic pay scales for consultants. The current pay scale for consultants rewards length of service more than contribution or performance, and provides less of an incentive for job growth or development than we would expect, with, in practice, only a weak link to appraised performance. We think that the parties should review the basic pay scale, with a view to moving the emphasis towards rewarding performance and encouraging career development, and away from paying for length of service.

We also observe that a single consultant grade, often attained relatively early in an individual's career, limits the opportunities for career development and job growth. We would like the parties to consider introducing a principal consultant grade, to which experienced, high-performing consultants, who are undertaking larger roles in terms of service delivery, expertise or leadership could be promoted.

Our recommended integrated package, including observations on a career structure for consultants, is presented in Figure 1 below. The three elements of local awards, national awards and changes to pay scales, with progression on basic pay scales linked to performance, and a new principal consultant grade, are intended to be viewed as an integrated package designed to recruit, retain and motivate consultants. It is, in our view, a balanced and affordable package which can be funded from current budget allocations for award schemes and will provide incentives to consultants at all career stages. High-performing consultants could expect to be recognised by their employers, and some exceptional individuals could expect to be promoted to the principal consultant grade, as well as to hold both local and national awards. We believe that the requirement to re-earn local and national awards regularly will motivate consultants to strive constantly for excellence in the NHS, which will be reflected in the highest level of service delivery and outcomes for patients.

Figure 1: Our proposed integrated package for consultants



We present a summary of our report in the following pages. This outlines our recommendations and observations for the future structure of consultants' award schemes and pay scales together with our comments and conclusions. Evidence and further detail is contained in Chapters 1 to 10 and the appendices.

Chapter 1 – Introduction

1. We have been asked by the United Kingdom Health Ministers to review compensation levels and incentive systems and the various Clinical Excellence and Distinction Awards schemes for NHS consultants at both national and local levels. Our terms of reference (see Appendix A) asked us 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, and 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 terms of reference also stated that we may make observations, rather than recommendations, on basic pay scales.
2. In this report we make recommendations and observations on the compensation of around 46,100 consultants and 2,800 clinical academics holding honorary NHS contracts; around half of these currently hold a local or national award, at a total cost

of over £500 million – nearly 8 per cent of the consultant pay bill. We have consulted widely, and considered fully written and oral evidence from a range of bodies and individuals, and compiled further evidence and research to support our conclusions.

Chapter 2 – The history and purpose of the awards system

3. Schemes to provide consultants with some form of financial reward for exceptional achievements and contributions to patient care have been in existence since the beginning of the NHS in 1948. Further information on the history and purpose of the schemes is contained in Chapter 2.

Chapter 3 – Other public sector and NHS incentive schemes

4. We have considered in Chapter 3 issues of comparability with incentive schemes elsewhere in the public sector and the NHS, and have concluded that there are not any other types of award schemes that would appear to be a satisfactory model to apply to consultants.

Chapter 4 – Compensation levels and incentives

5. The total reward package for consultants, taking into account pay (including Clinical Excellence Awards/Distinction Awards/Discretionary Points), benefits, learning and development, and work environment, is extensive. Basic pay, on average, comprises around three-quarters of a consultant's total NHS earnings. We have assessed the pay position of consultants relative to other groups that could be considered comparator professions, and conclude that the overall level of compensation for consultants is appropriate. However, this review has identified a number of aspects with the current total reward package for consultants with which we have some concerns. Our observations and recommendations in this report are intended to address those concerns.
6. Research into current remuneration methods for medical and dental consultants in other countries found that, while there were a variety of arrangements for making additional payments to senior doctors, based on merit, performance, seniority and choice of speciality and geographic location, there was not evidence of any schemes similar to the Clinical Excellence and Distinction Award schemes in the United Kingdom.

Observations on the basic pay scale

7. We make the following observations on the basic pay scale. The current basic pay scale for consultants in England, Scotland and Northern Ireland has eight pay points. Points 2 to 5 are awarded annually for the first four years in post, points 6 to 8 are awarded after each subsequent five years of service, so it takes a consultant 19 years to reach the pay band maximum. Pay progression is dependent on an individual fulfilling their job plan and participating in the appraisal process; in practice, few increments are withheld. While we recognise that performance should increase with the years in a job, we believe that the extent to which experience alone is rewarded should be more limited than the current pay scale permits. We believe that the current system pays increments for a consultant continuing to carry out their basic job, rather than reflecting the evidence of job growth that a progression system should reward. It is our perception that the current structure rewards length of service more than contribution or performance, and provides less of an incentive for job growth or development than we would expect, with, in practice, only a weak link to appraised performance. Near-automatic progression is not typically a feature of the professional roles we use for comparators at this level.
8. The consultant pay scale in Wales, with Commitment Awards made on a time-served basis, on top of the basic pay scale, exacerbates this issue. We are unable to support

a pay system that rewards length of service, for up to 30 years, rather than the achievement of excellence.

9. We urge the parties to review the basic pay scale, with a renewed emphasis on rewarding performance and encouraging career development. We would like to see the pay scale limit progression for all effective/satisfactory performers to the first five pay points (currently to £83,829), with no fixed pay points beyond this, apart from the maximum. We expect all consultants to be clinically capable in their role: sub-standard performance should be addressed robustly outside the reward system. Further progression towards the maximum would be a matter for the local employer to determine, on the basis of individual performance. We recognise that implementation of such a system would require an effective performance management system. We also recognise that this will mean that some consultants may not reach the maximum of the pay scale.

Observation 1: The parties should review the basic pay scale, with a view to moving the emphasis towards rewarding performance and encouraging career development, and away from paying for length of service.

Principal consultant grade

10. Allied to our comments on the basic pay scale, we observe that a single consultant grade, often attained relatively early in an individual's career, limits the opportunities for career development and job growth. We would like the parties to explore introducing a principal consultant grade, to which experienced, high-performing consultants, who are undertaking a larger role in terms of service delivery, expertise or leadership can be promoted. Over time, we would expect only a small proportion of consultants, say up to 10 per cent, to reach this level, following a rigorous process for appointment, and such a grade should not just reward time served. We would expect the number of available posts to be determined locally to meet the needs of each employing organisation, with the option to move consultants in and out of the grade. The initial salary for this grade would take the form of a 10 per cent pay increase on promotion, from any point in the main consultant pay range. The maximum salary for the grade would be £120,000, with any progression within the range based on performance and contribution, at the employer's discretion. The salary for the principal consultant would be consolidated and pensionable. If principal consultants are moved back into the main consultant grade, we do not believe that any pay protection provisions should apply. Principal consultants would also be eligible for the new award schemes outlined in Chapters 5 and 6, but this new grade would not be open to those still in receipt of an award under the old schemes: we see this new grade as part of an integrated package with the new award schemes. We envisage that certain posts within an organisation may be designated as principal consultant positions and filled from external or internal recruitment, while, in other cases, individuals undertaking highly specialist and demanding roles may be promoted to this grade.

Observation 2: The parties should consider introducing a principal consultant grade.

11. Our observations on pay scales are part of an integrated package for consultants which should be implemented alongside our recommendations for the new award schemes.

The need for incentives

12. The consultant body is large and heterogeneous, and the reward structure needs to recognise differences in the scope of jobs undertaken, the excellence with which the roles are performed, and the many opportunities for consultants to work beyond their basic jobs. A new principal consultant grade would recognise sustained, outstanding

performance in roles that carry more responsibility, leadership, specialism, or that make particular demands on the job holder; while a revised consultant grade would enable excellent performers to be rewarded and encourage career development. We believe that variable award schemes are also required, however, to reward, recognise and provide incentives for those consultants who go significantly beyond their basic job, both in terms of providing a service to patients, and in contributing to the development of the NHS as a whole, through research, teaching, professional development or developing innovative practice. It is appropriate for this element of pay to be non-consolidated: first, because such a contribution is variable and discretionary; second, because it is likely to change over time; and third, because it incentivises continued high levels of performance. Non-consolidated awards enable the available pot of money to be targeted at current excellence, rather than being a retrospective payment that continues to reward contributions made in the past.

Recommendation 1: We recommend that consultants continue to receive reward above their basic pay scales, where appropriate, and are eligible for incentives to reward excellence.

13. Non-pay incentives could form an important part of the total reward package for consultants. They can contribute to motivation in a cost-effective way. Any non-pay incentive schemes should be designed to take account of both the intrinsic motivation of consultants and the nature of the health service in which they work. Consultants are typically highly-motivated individuals, committed to the provision of an excellent public health service. However, care needs to be taken in designing schemes to ensure that they support the existing commitment of consultants without devaluing it.

Reviews of senior pay in the public sector

14. The Review Body on Senior Salaries (SSRB) published an *Initial report on public sector senior remuneration* in March 2010 which included a draft Code of Practice to provide guidance to those responsible for setting senior pay. The draft Code was intended to apply to all senior public sector executives and, in principle, to anyone earning more than £100,000 a year, which would include many medical and dental consultants.
15. The *Hutton review of fair pay in the public sector* published its final report in March 2011. The report was strongly in favour of performance pay for senior staff in the public sector and proposed a Fair Pay Code building on the SSRB draft Code of Practice on senior pay. It also advocated the use of 'earn-back pay' for senior public servants, whereby executives would have an element of their basic pay that needed to be earned back each year through meeting pre-agreed objectives; excellent performers who went beyond their objectives should be eligible for additional pay.
16. We agree with the need to not only reward good performance, but for any performance scheme to feature equivalent downside risks for poor performance. These principles can be taken forward in local award schemes in particular, though we stress that for any performance system to work well, a robust and fair system for judging performance is required. The government will decide how to implement both the Hutton review of fair pay, and the SSRB's work on public sector senior remuneration. We will consider how these reviews affect our remit groups in our future reports, when the government has indicated how the recommendations are to be implemented.

Chapter 5 – Local awards

Commitment Awards in Wales

17. While we acknowledge the right of Wales to implement a system of Commitment Awards in place of a local award scheme, we are not recommending that the other countries of the United Kingdom adopt a similar model. Indeed, during oral evidence we explored with the parties whether they wished to pursue such a model, and they were all very clear that they did not wish to follow the Welsh approach. We understand that one of the reasons for Wales introducing a system of Commitment Awards was to act as a tool to improve retention of consultants: while retention in Wales does appear to have improved, it is also the case that retention has improved across the United Kingdom. It is therefore difficult to ascertain the extent to which the improvement in retention in Wales is due to Commitment Awards, as opposed to other aspects of the new consultant contract, including improved pay. In the absence of any firm evidence on the benefits of Commitment Awards, we are unable to support a pay system that rewards length of service, in this case for up to 30 years, rather than the achievement of excellence.

Framework for new local award schemes

18. We have given much thought to the evidence provided by the parties on local award schemes. We have been struck by the large number of levels of local awards – nine in England, and eight in both Scotland and Northern Ireland, with Scotland proposing to introduce a further two levels. We do not believe it is necessary for there to be so many levels, which may lead to difficulties in assessing the incremental contributions of individual consultants. We set out in Chapter 4 our view that the current structure rewards length of service more than contribution or performance, and provides less of an incentive for job growth or development than we would expect, with, in practice, only a weak link to appraised performance. Near-automatic progression is not typically a feature of any of the professional roles we use for comparators at this level. We are also concerned that, with the exception of local awards in Northern Ireland and level 9 awards in England, local awards are not subject to any form of review, so there is no assessment of whether the contribution of individual consultants is being maintained. The only assessment appears to be when individuals apply for a higher level of local award.
19. It is apparent that the existing local award schemes and the job planning and performance appraisal processes were created separately, without any serious thought as to their integration. This stands out as an obvious flaw with the current system. For the future, we believe there should be a much stronger link between local awards and performance appraisals of consultants. It would no longer be appropriate for individual consultants to apply for local awards: employers should make decisions as to which of their consultants are the most deserving in any one year by an assessment of their job performance. We believe that job performance should be assessed on the basis of the knowledge, skills, expertise and competence that employees apply to the job, how they behave in carrying out their work, the results that employees achieve against both their employing organisation and individual objectives, and their impact on the employing organisation. The schemes should reward clinical excellence; the quality of outcomes; teaching, research and innovation; and the delivery of the employing organisation objectives for improving patient care, using objective measures such as patient outcomes and patient feedback, where appropriate.
20. Local award schemes should be competitive, with awards being made to the highest performing consultants, say 25 per cent of consultants working within each employing organisation. As the awards are to be linked to job plans and objectives, we believe there is a strong argument for the associated awards to be one-off annual lump-sum payments, particularly as the setting of objectives normally relates to an annual cycle. There may be exceptional cases where the employing organisation considers that the achievement of

objectives warrants an award for a period exceeding one year, perhaps when the benefits of the achieved objectives are felt over a prolonged period, although in such a case, it could be dealt with by adjusting the size of the award. In any case, we believe that one-year local awards should be the norm, and that the maximum length of a local award should be for three years in exceptional cases, to be paid in annual lump-sum payments. When payments are made over a period in excess of one year, it will be important that the performance level of recipients remains at an appropriate level, which should be confirmed by 'sign-off' from the employing organisation Chief Executive on an annual basis.

21. We acknowledge the concern that our proposal for annual one-off awards could suggest an additional administrative burden on employers. In response, we would simply say that if employers are already demonstrating best practice with regular job planning, objective setting and performance appraisal, then they should already have the tools to hand to enable them to deliver our proposed new local scheme.
22. As we envisage the new awards as one-off payments, then no issue arises over the ongoing payment of awards without review. For those consultants currently in receipt of local awards, we recognise that one of the accrued rights of such award holders is that they should be able to retain their award subject to satisfactory periodic review. In the future, we believe that all holders of existing local awards should have their awards reviewed regularly, the length of time between reviews to be determined by the awarding organisation, but with a presumption for annual reviews. Where appropriate, the reviews should allow for the possibility of the withdrawal or downgrading of awards. When the withdrawal or downgrading of awards does occur, subject to accrued rights, we do not believe that pay protection should apply.
23. With the changes we are recommending for the award schemes, to make them non-consolidated and non-recurrent, we think it is no longer appropriate for local awards to be pensionable.
24. The Department of Health said that it wanted to leave it up to individual employers whether or not to have local award schemes. While we are content for local employers to have discretion over decisions about local schemes, we stress the importance of all employing organisations having local award schemes in place to recognise the valuable contribution that consultants make towards delivering the objectives of employing organisations. We do have some reservations linked to the funding and affordability of such schemes, and suggest that consideration be given to agreeing a cap on the cost of local schemes. We believe that decisions on local schemes should take place within a United Kingdom-wide framework of common principles and governance.

Recommendation 2: For local award schemes, we recommend that such schemes should operate within a United Kingdom-wide framework of common principles and governance and should include the following:

- all employing organisations should have a local award scheme in place;
- there should be measurable targets linked to both the objectives of the employing organisation and the individual objectives of consultants;
- the system should be transparent, fair and equitable;
- awards should be linked to performance appraisals and should be made only for work that is done over and above job plans;
- awards should not reward activity already remunerated elsewhere, for example through additional Programmed Activities or Supporting Professional Activities, unless the outcomes are significantly above expectations;
- consultants should no longer need to apply for local awards – all would be eligible. Employing organisations should make decisions as to which of its consultants were the most deserving in any one year;
- schemes should operate within a competitive environment, to reward a limited percentage of consultants working for an employing organisation within any one year;
- nationally, the parties should agree a cap on the cost of local schemes;
- under the new schemes, local and national awards may be held simultaneously;
- awards should be non-consolidated and non-pensionable;
- one-year local awards should be the norm, and the maximum length of local award, in exceptional cases, should be three years, to be paid in annual lump-sums;
- awards in excess of one year should require 'sign-off' by the employing organisation Chief Executive on an annual basis;
- all existing award holders should have their awards reviewed on a regular basis, the awarding organisation to decide the length of time between reviews (but with a presumption for annual reviews) and with no grace period;
- subject to accrued rights, there should be no pay protection; and
- subject to accrued rights, consultants who retire and return to work should not retain any local award, although they should be eligible for consideration for new local awards alongside other consultants.

25. We recognise that there will be a number of detailed issues arising from our recommendation on a United Kingdom-wide framework of common principles and governance for local schemes: for example, the number of levels of local awards, the

number of consultants in receipt of awards and the value of individual awards. NHS Employers has indicated that it believes that the fine detail of the new scheme should be left for it to negotiate with the parties and we are content with that proposal. England, Wales, Scotland and Northern Ireland will each need to consider how they wish to take forward our recommended framework to reflect their particular circumstances: we note that not every country is looking for local flexibility for local schemes, but observe that our recommended framework for local awards could apply equally to a national scheme within each country. If Wales were to adopt our recommended model for local awards, it would need to give thought as to how such a scheme would interact with its existing pay scale and Commitment Awards. We do not think it appropriate for consultants to receive both local awards and Commitment Awards, but if Wales wished to relinquish Commitment Awards, then it would probably need to reconsider the pay points for its main consultant pay scale, as its current pay scale appears to build in assumptions on progression using Commitment Awards.

26. As the details of any future local schemes are to be determined through negotiation, we are not in a position to be able to comment on the overall affordability of the schemes, although we note that as we are recommending that awards should no longer be pensionable, this will have a significant impact on their cost. We have also suggested that local award schemes should operate in a competitive way, with awards going to, say, the highest performing 25 per cent of consultants, and that there should be a cap on the cost of local schemes. We set out an example in Chapter 10 of how we envisage a local scheme might operate, with four levels of award, to be given to 25 per cent of consultants in each year. We estimate that, on average, consultants would receive approximately 4.1 per cent of their basic salary as a lump sum – which equates to approximately 2.6 per cent of the total consultant pay bill. This would release funding which, together with funds released from the national awards scheme, would be sufficient to enable the creation of the principal consultant grade that we describe in Chapter 4. Our suggestion for how a local scheme might operate is not intended to be binding on the parties, but is to illustrate the affordability of such an arrangement.
27. It will be important for us to be able to continue to monitor the amount of funding that is being channelled into local award schemes, as this forms an essential part of our wider work on pay comparability. We recognise that this will not be as simple as at present, particularly if employers set up their own local award schemes in the future. We therefore ask the Health Departments to set up mechanisms, where necessary, so that they are able to report back to us on an annual basis the level of funding for consultants' local award schemes. We would expect this information to form part of the normal submission of annual evidence to us.

Recommendation 3: We recommend that the Health Departments provide annual evidence to DDRB on the level of funding for local award schemes.

28. We set out in Chapter 10 how, when consultants leave the NHS, some of the funding for existing national awards should be transferred to employing organisations, to add to the funding for the new local schemes and implementation of the new principal consultant grade.
29. Our recommendation on a United Kingdom-wide framework of common principles and governance states that local award schemes should be transparent, fair and equitable. As the design of local schemes will, in future, be largely for employing organisations to decide, they will need to give particular attention to this principle. We would expect all employing organisations to publish data on the awards made annually and details of their local award schemes. These data should be provided to the national database

and recorded in a consistent manner across NHS organisations, to enable monitoring, auditing and analysis.

Recommendation 4: We recommend that employing organisations publish annual data on the awards made and details of their local award schemes.

Chapter 6 – National awards

Review of awards versus new application

30. We believe that national awards should be held for a period of up to an absolute maximum of five years. The duration of an award should be decided by the awarding body at the time the award is made, and should be related to the sustainability of the achievements being rewarded, rather than based on administrative simplicity. Consultants should be free to make a new application for an award at any time. We believe that this should help to ensure that only the most deserving consultants are in receipt of an award at any point in time.

Eligibility for awards

31. We believe that applications for national awards should be via self-nomination, and that it should be the role of the awarding bodies to make an assessment of the applications and to rank them in order. Awards would be made based on the quality of applications and judged on their individual merits. It would therefore no longer be necessary for individuals to apply for a given level of award, although we think it would be helpful to applicants if the awarding bodies were to publish guidance on the criteria expected at each level of award. Furthermore, we do not see a need to restrict access to eligibility for national awards to any particular length of service: all consultants should be able to apply for a national award at any point in their career. Success or failure will be determined by an assessment of their applications relative to all others in any one year.

Bronze awards and level 9 local awards

32. The Advisory Committee on Clinical Excellence Awards (ACCEA) concluded in its submission to us as part of our normal 2011-12 round, that it appeared that two pyramids had emerged for national and employer-based awards and that it seemed likely that for many consultants, a level 9 award represented a ceiling. This evidence suggests that there is a strong need for the continuation of an entry-level award at national level. This will be particularly important, given that we are recommending the separation of the local and national award schemes. We set out our view in Chapter 5 that the design of local award schemes should be left to local discretion, albeit within our recommended United Kingdom-wide framework of common principles and governance.

Accrued rights

33. We are required by our terms of reference to respect the accrued rights of individuals. The parties, however, were not able to provide us with an agreed definition of what those accrued rights are. Ultimately, the extent to which pay protection is an accrued right is an issue for the parties to settle. However, subject to accrued rights, we agree that any future national scheme should not include any provisions for pay protection. We note that this would allow funds to be released for additional national awards for other applicants who meet the criteria.
34. Subject to accrued rights, we believe that any consultant who moves onto the new award schemes should no longer retain any award held under the existing award schemes. Our recommendations on transition arrangements are contained in Chapter 10.

35. As with pay protection, it is not clear to us whether the retire and return provision for holders of Distinction Awards (and perhaps Discretionary Points) would fall within the scope of accrued rights for which we are required under our terms of reference for this review to respect. This is properly an issue for the parties to determine. Nevertheless, we wish to place on record our view that, subject to accrued rights, we believe that under any scheme, consultants who retire and return to work should not retain their national awards, although we believe that they should be eligible to apply for a new national award in the same pool as new applicants.

United Kingdom-wide framework of common principles and governance for a national award scheme

36. As with any future local schemes, we believe the detail of any future national schemes should be determined through negotiation. We have set out in Chapter 10 an example of what we envisage for a national scheme: four levels of award, of £10,000 per annum, £20,000 per annum, £30,000 per annum and £40,000 per annum, to be awarded to 4 per cent, 3 per cent, 2 per cent and 1 per cent of consultants respectively. The new national schemes would operate in parallel with the new local schemes, so consultants would be eligible to receive payments under both schemes simultaneously. We believe that a national award should be held for a period of up to an absolute maximum of five years. We think it should be for the parties to discuss the criteria necessary for determining both the level of award and its duration, but as a general guideline, we would expect the impact of the achievements being rewarded to relate to the level of award, and the sustainability of the achievements being rewarded to relate to the duration of the award. Ultimately, it should be the role of the awarding body to determine the duration of an award using the agreed criteria. We would like to see more flexibility in the duration of national awards so that the full range of up to five years is used. We believe that a maximum of 10 per cent of all consultants should be in receipt of a national award at any point in time. We estimate that such a scheme would cost approximately £91.2 million in England. Our suggestion on the levels of award and percentages of consultants who might receive them is not intended to be binding on the parties, but we consider the arrangement we describe in Chapter 10 to be both appropriate and affordable.
37. While we envisage that the national award schemes will reward those consultants with the greatest sustained levels of performance and commitment to the NHS and whose achievements are of national or international significance, we also consider it important that recipients of national awards are also meeting the objectives of their employing organisation. We therefore believe that it should be a requirement that all national award holders receive 'sign-off' from the Chief Executive of their employing organisation. This 'sign-off' should be provided on an annual basis to cover the length of any national award.
38. With the changes we are recommending for the award schemes, to make them non-consolidated and non-recurrent, we think it is no longer appropriate for national awards to be pensionable. We believe that national award schemes should take place within a United Kingdom-wide framework of common principles and governance.

Recommendation 5: For national award schemes, we recommend that such schemes should operate within a United Kingdom-wide framework of common principles and governance and should include the following:

- awards should recognise those consultants with the greatest sustained levels of performance and commitment to the NHS and whose achievements are of national or international significance;
- the system should be transparent, fair and equitable;
- awards should be made only for work that is done over and above job plans;
- awards should not reward activity already remunerated elsewhere, for example through additional Programmed Activities or Supporting Professional Activities, unless the outcomes are significantly above expectations;
- under the new schemes, local and national awards may be held simultaneously;
- all successful national awards should require 'sign-off' by the employing organisation Chief Executive on an annual basis;
- application for an award should be by self-nomination;
- the cost of national awards should continue to be met centrally;
- awards should be non-consolidated and non-pensionable;
- awards should be held for a period of up to an absolute maximum of five years, the length of which should be determined by the awarding body at the time of granting the award and should be linked to the sustainability of the achievements;
- the level of the national award should be linked to the impact of the achievements;
- consultants should be able to apply for a new award at any time;
- subject to accrued rights, there should be no pay protection;
- existing awards that remain subject to review should not include any grace period; and
- subject to accrued rights, consultants who retire and return to work should not retain any national awards, although they should be eligible to apply for a new national award in the same pool as new applicants.

Chapter 7 – Clinical academics

39. Clinical academics are doctors or dentists who are employed by Higher Education Institutions, or other organisations, in a research and/or teaching capacity and who also provide services for NHS patients as part of honorary NHS contracts. Nearly two-thirds of clinical academics in each country held an award in 2010, a higher proportion than

NHS consultants. The share of national awards held by clinical academics increases with the level of award, so that over half of the highest awards (platinum Clinical Excellence Awards and A+ Distinction Awards) are held by that group.

40. As clinical academics are not part of our usual remit group, we are not normally responsible for making recommendations on any element of their remuneration, although clinical academics are affected by the recommendations in our annual reports on the consultant pay scales and the various award schemes to which they have access alongside NHS consultants.
41. Our recommendations on the compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants in this review are based on the evidence and our knowledge of NHS consultants, and take into account all aspects of our standing terms of reference. We received some anecdotal evidence that the number of clinical academics had declined prior to the introduction of Clinical Excellence Awards, but that since then, numbers of clinical academics had stabilised. While some of the parties have written to suggest that recruitment has become more difficult, we do not have a clear indication as to the required number of clinical academics necessary for the United Kingdom to enable us to make an informed judgement as to the appropriateness of the current levels of remuneration. That is, we believe, for their employing organisations to determine, taking account of the wider circumstances surrounding clinical academics.
42. Having said that, we believe that in principle, clinical academics should have access to any new award schemes that are introduced for NHS consultants. We recognise that clinical academics are highly valued and are carrying out important work for the NHS, and believe that they should therefore be eligible to receive the same rewards that NHS consultants are able to access for their contributions to the NHS. We note that clinical academics are a highly mobile group, and we consider that their reward package should be such that the United Kingdom remains one of the leading countries in the world for medical research.
43. Our description of how national award schemes might operate in the future (in Chapter 6) proposes that applications are made for a national award, and it will be the responsibility of the awarding bodies to rank applications and make awards of appropriate duration and size. Clinical academics, as with NHS consultants, will therefore be eligible to receive all levels of national award without a requirement to progress through the different levels of award. The key consideration will be an assessment of an individual's contribution to the wider NHS. Clinical academics will also be eligible for local awards under the new scheme we describe in Chapter 5: clinical academics hold a small proportion of local awards, so our recommendation to reduce the value of national awards, to reflect the fact that local and national awards can be held simultaneously, may affect the total remuneration received by some clinical academics via the awards. It will therefore be important for employing organisations to ensure that clinical academics are properly considered within local schemes, so that their local contribution is adequately rewarded alongside any national contribution.
44. We note that Scotland intended making clinical academic general medical practitioners eligible for its proposed new system of Scottish Consultants' Clinical Leadership and Excellence Awards, but that in Northern Ireland, clinical academic general medical practitioners are not eligible for Clinical Excellence Awards. We ask Northern Ireland to consider whether or not this position continues to be appropriate, particularly if there are any recruitment or retention issues for this group.

Recommendation 6: We recommend that clinical academics holding honorary NHS contracts continue to have access to any future local and national award schemes alongside NHS consultants.

45. In its evidence to us, ACCEA commented that it was aware that some employers were paying clinical academics at remuneration levels equivalent to national Clinical Excellence Awards in order to recruit doctors and had underwritten this amount pending successful applications for awards. We explored this issue during oral evidence, as it raised a possible concern: it would appear to introduce the potential for some level of bias in the advice that employing organisations make to the awarding bodies for the various awards, particularly for national awards where the funding of awards moves from the employing organisation to a central fund. None of the parties indicated to us that they thought that the award process was being undermined by this issue. Despite such assurances, we remain uneasy that awards may be being used to compensate for an inadequate pay system: we believe that universities should pay an appropriate level of remuneration necessary to recruit and retain sufficient numbers of suitably qualified and experienced clinical academics. The award schemes should then provide supplements to basic pay for those making a substantial contribution to the NHS either at a local or national level.

Chapter 8 – Pension issues

46. Though we have yet to see the government's detailed proposals for the NHS pension schemes in response to the reports by the Independent Public Service Pensions Commission, we have been informed by the Commission's deliberations in making our own recommendations.
47. We are conscious that the switch in pensions indexation from the Retail Prices Index to the Consumer Prices Index from April 2011 will affect the value of future pensions payments. Furthermore, the changed tax regime, that reduces the annual allowance for tax relieved pension savings to £50,000 from April 2011 and the lifetime allowance to £1.5 million from April 2012, will affect the highest earners in our remit group.
48. There is no doubt that awards being pensionable under a final salary scheme is of very high value to individuals, and that neither the contributions paid by the individual nor the employer reflect the full current cost of these benefits.
49. If accepted, the recommendations we have made in Chapters 5 and 6 mean that, in future, awards will be time limited, and not form part of basic salary. We can understand why, at the introduction of the award schemes in 1948, it was felt necessary to make these awards consolidated and pensionable. We recognise that a career average approach may be introduced, but as a point of principle, with the changes we are recommending for the award schemes, we think it is no longer appropriate for the awards to be pensionable. This is consistent with practice across the public and private sectors. Individuals have the option to make additional voluntary contributions from their award to the NHS (or a private) pension scheme.

Recommendation 7: We recommend that payments made under any new award scheme, at national or local level, should be made on a non-pensionable basis.

50. We also believe that existing awards should become non-pensionable in future. Leaving them pensionable for future service would create a differential between consultants on the current and the new schemes, and act as a disincentive to participate in the new award schemes. Individuals' accrued rights should be protected, however, so that the

cash value of an existing award would remain pensionable for past service. A suitable period of notice, to be determined by the parties, should be given before these changes are implemented, so as not to cause undue disruption to those planning to retire soon.

Recommendation 8: We recommend that existing awards are no longer pensionable for future service, following a suitable transition period, to be determined by the parties.

51. These recommendations will deliver significant savings to the cost of future pensions and we are aware that they will, viewed in isolation, reduce the value of the total reward package to consultants in receipt of the awards. The value of the awards may need to be considered in future in the light of this, and the impact on retention, particularly for those near to retirement age, will need to be monitored closely. We will continue to assess the value of the total reward package relative to comparator groups in our future reports.

Chapter 9 – Governance and operation of the award schemes

Criteria/domains for awards

52. We do not see it as our role to go into depth on the domains, as we believe that it is a matter for the parties to agree.

Recommendation 9: We recommend that, in the light of the changes that we are recommending for the schemes, the awarding bodies should revisit the domains and their weightings, in particular to distinguish elements of the domains with a local focus from those elements with a national focus, while ensuring that work carried out at a local level for the wider NHS is still recognised.

Recipients of awards

53. We note the concerns about the eligibility for awards of consultants working in private practice. However, we believe that the opportunity to carry out private work is part of the total reward package for consultants and that the award schemes should continue to apply to all consultants working in the NHS. As the schemes aim to reward those consultants making a sustained contribution to the NHS we would expect the schemes to favour those consultants who are most committed to the NHS.
54. We have addressed many of the concerns about the recipients of awards in the United Kingdom-wide framework of common principles and governance that we have proposed for the new national and local award schemes. Our principles state that awards should only be made for work that is done over and above job plans; and that awards should not reward activity already remunerated elsewhere, for example through additional Programmed Activities or Supporting Professional Activities, unless the outcomes are significantly above expectations. Following the implementation of our recommendations we expect to see a system that is even more transparent than at present and fair and equitable to all.

Transparency, fairness and equity

55. We believe that transparency, fairness and equity are fundamental principles under which all the award schemes should operate. As the schemes continue to develop, following implementation of our recommendations, we would expect to see further improvements in the transparency of the schemes. For example, we think it is important that the awarding bodies should provide clear feedback to interested parties when their decisions

are questioned. We have also recommended in Chapter 5 that employing organisations should publish annual data on the awards made and details of their local award schemes.

56. A number of respondents to our consultation questioned whether it was fair and equitable that the scheme should be confined to consultants. We have made some observations on this issue in Chapter 4, but it would be outside our remit to make recommendations with regard to any group other than consultants or clinical academics with honorary NHS contracts.

Recognition of work for Royal Colleges

57. We have not received any evidence to convince us that national awards should not recognise exceptional work for the Royal Colleges. We think that all work done for the NHS should be capable of being rewarded and that success should be determined by whether the outcomes of such work are significantly above expectations. We believe therefore that work undertaken for the Royal Colleges should continue to be recognised through the award schemes, where appropriate.

Recommendation 10: We recommend that work undertaken for the Royal Colleges should continue to be recognised through the award schemes, where appropriate.

Public health consultants and Directors of Public Health

58. In our view, as these individuals are carrying out work for the NHS, they should continue to be eligible for the award schemes and the rules and guidance should be amended to ensure their continued inclusion in the schemes.

Recommendation 11: We recommend that public health consultants and Directors of Public Health should continue to be eligible for the award schemes and that, in the light of the forthcoming changes in England to their employment arrangements, the rules and guidance should be amended to ensure their continued inclusion in the schemes.

Assessment of applications for national awards

59. We believe that it is important that the assessments for national award holders should have input from clinicians, employers and lay members, with the ultimate decisions resting with national awards committees. We do not believe it is appropriate for the Chair and Medical Director of national awards committees to be the final decision makers. We are not convinced that the current composition of members in the national awards committees is the most appropriate, where clinicians form half the total with employers and lay members making up the remainder. In our view an equal ratio (for example 6:6:6) of clinicians (some of whom may be academics), employers and lay members would be a more balanced committee. We recommend in Chapter 5 that all existing local awards should be subject to regular review. We believe that the employer-based awards committees that conduct such reviews should have a similar constitution to that of the national awards committees.

Recommendation 12: We recommend that, in order to form a balanced committee, the composition of members in the national awards committees should be comprised of an equal ratio (for example 6:6:6) of clinicians (some of whom may be academics), employers and lay members, and that the ultimate decisions on national awards should rest with the national awards committees. We recommend that employer-based awards committees conducting reviews of existing local awards should have a similar constitution to that of the national awards committees.

Chapter 10 – Affordability and transition arrangements

Affordability and value for money

60. It is difficult to assess how much value for money the current schemes offer; to an extent this is a matter of perception, as the schemes are not formally linked to outcomes. We recognise that the awards are perceived by the medical profession as having a strong influence on recruitment and retention, and provide both an incentive to work beyond the job role and recognition for doing so. However, we are concerned that awards should not reward activity already remunerated elsewhere, for example through additional Programmed Activities or Supporting Professional Activities, unless the outcomes are significantly above expectations.
61. In the new schemes, we would like to see a stronger link to performance with improved links to measures of activity, quality of patient care, patient feedback, cost and a clear definition of excellence for each discipline. We believe that it would be most appropriate for the Royal Colleges and equivalent bodies to determine these definitions of excellence. We think it is important that the operation of the schemes should provide a level of assurance that only the highest performing consultants are in receipt of an award. The type of awards that we have recommended will have to be re-earned and we believe they should also have a more immediate impact on motivation and engagement. We consider it inappropriate for awards to be used, to all intents and purposes, as an extension of basic pay, as is the case at present, and we believe that it is essential that the award schemes should be run in a transparent, fair and equitable way. Our costings in Chapter 10 based on data for England suggest that, at any one time, it would be affordable for 25 per cent of consultants to hold local awards and 10 per cent of consultants to hold national awards. We believe that this will provide a real opportunity for the contributions of the highest performing consultants to be recognised.

Recommendation 13: We recommend that, in order to obtain value for money from the consultants' award schemes, there should be a stronger link to performance with improved links to measures of activity, quality of patient care, patient feedback, cost and a clear definition of excellence for each discipline. We recommend that the Royal Colleges and equivalent bodies define excellence for their disciplines.

The cost of our recommendations

62. We estimate that for England, the only United Kingdom country for which we had sufficient data to carry out our analysis, the cost of our recommendations would be: £91.2 million per annum after nine years, for national awards; £140 million per annum for local awards; and the immediate cost of implementing our proposed, principal consultant grade would be £44 million, including employers' National Insurance and pension contributions. The total cost of our illustrative examples in England, which comes to £275 million to £335 million at April 2011 values (compared with a current spend of £425 million), could be met through using funds freed up by consultants leaving the NHS who currently hold local and national Clinical Excellence Awards.

63. We note, however, that based on our assumptions it could take up to nine years to fully implement our example schemes, and it would take a number of years for existing schemes to be phased out. This will limit the funding available for the new schemes in the short to medium term. We think it appropriate that some of the funding for existing national awards should be transferred to employing organisations to add to the funding for the new local schemes and implementation of the new principal consultant grade.

Recommendation 14: We recommend that the parties give consideration to how some of the funding released from existing national awards is redistributed to employing organisations to add to the funding for the new local schemes and implementation of the new principal consultant grade.

Accrued rights

64. We believe that it is for the parties to agree the substance of the accrued rights held by existing award holders.

Transition arrangements

65. We are conscious of the importance of appropriate transition arrangements so that, for example, those consultants currently holding awards are not disincentivised by the changes, and encouraged to retire earlier. We also recognise that many individuals have accrued rights under the current and previous schemes and our comments on specific accrued rights appear earlier in the report. We would like to see the new schemes for national and local awards introduced at the earliest opportunity and award holders encouraged to move from the existing schemes, as we think it is counter-productive to have legacy schemes that continue for a long time. Our intention is that award holders should not be able to hold awards simultaneously on the old and the new schemes, and that it should be implicit in accepting an award under the new schemes, or moving into our proposed new principal consultant grade, that individuals must relinquish any awards under the current or previous schemes. However, as we have recommended elsewhere in the report, it will be possible to hold local and national awards at the same time under the new schemes. We would also like the parties to consider carefully ways in which award holders could be encouraged to move from the old schemes for local and national awards to the new, while respecting accrued rights.

Recommendation 15: We recommend that award holders should not be able to hold awards simultaneously on the old and new schemes, and that it should be implicit in accepting an award under the new schemes, or moving into our proposed new principal consultant grade, that individuals must relinquish any awards under the current or previous schemes.

Recommendation 16: We recommend that the parties consider carefully ways in which award holders could be encouraged to move from the old schemes for national and local awards to the new, while respecting accrued rights.

2012 awards round

66. We do not think it is for us to decide whether the award schemes should be suspended in Scotland, nor whether the Department of Health should hold a round for Clinical Excellence Awards in 2012. We believe these to be decisions for the governments, in consultation with the parties. However, while we accept that a consultation on our recommendations could take several months, we would still expect the new schemes

based on our recommendations and observations to be launched in 2012 and implemented by 2013.

Conclusions

67. This is a United Kingdom-wide review and our recommendations relate to the United Kingdom as a whole. We are conscious that the four countries may not accept all our recommendations and that in turn there is a risk, depending on the extent of differences between the countries, that this could lead to a cross-border movement of consultants. Other consequences of our recommendations that may occur are that existing award holders may be reluctant to move to the new schemes because they perceive the existing schemes to be more beneficial; or a dual system may arise between award holders on the current and those on the new schemes as a result of the need to respect the accrued rights of existing award holders. It is not our intention that our recommendations should lead to any perverse incentive for existing award holders to retire earlier. As we have said above, we would like to see the new schemes for national and local awards introduced at the earliest opportunity and award holders encouraged to move on from the existing schemes, as we think it is counter-productive to have legacy schemes that continue for a long time.
68. Consultants whose performance has declined since gaining an award, or whose performance is unremarkable, are less likely to benefit from our recommendations. However, we hope that the recommendation that all national awards should be subject to a new application will encourage all consultants to achieve and maintain high standards. Clearly, those who have up until now benefitted from what we see as anomalies in the current system, such as retire and return or pay protection, or those who have gained Commitment Awards without having to demonstrate excellence, may be less pleased with our recommendations. However, overall, we think that our recommendations and the United Kingdom-wide framework of common principles and governance upon which the award schemes should operate, alongside the improved access to the schemes, represent a positive way forward for the award schemes.
69. Our recommended integrated package, including observations on a career structure for consultants, comprises three elements: local awards; national awards; and changes to pay scales, with progression on basic pay scales linked to performance, and a new principal consultant grade. This is intended to be viewed as an integrated package designed to recruit, retain and motivate consultants. It is, in our view, a balanced and affordable package which can be funded from current budget allocations for award schemes and will provide incentives to consultants at all career stages. High-performing consultants could expect to be recognised by their employers, and some exceptional individuals could expect to be promoted to the principal consultant grade, as well as to hold both local and national awards. We believe that the requirement to re-earn local and national awards regularly will motivate consultants to strive constantly for excellence in the NHS, which will be reflected in the highest level of service delivery and outcomes for patients.

RON AMY, OBE (*Chairman*)

KATRINA EASTERLING

JOHN GLENNIE, OBE

DAVID GRAFTON

SALLY SMEDLEY

PROFESSOR STEVE THOMPSON

PROFESSOR IAN WALKER

DAVID WILLIAMSON

OFFICE OF MANPOWER ECONOMICS

7 July 2011

CHAPTER 1 – INTRODUCTION AND REMIT

Introduction

1.1 This report is divided into ten chapters comprising this introduction, and chapters on: the history and purpose of the schemes; other public sector and NHS incentive schemes; compensation levels and incentives; local (employer-based) awards; national awards; clinical academics; pension issues; the governance and operation of the award schemes; and affordability and transition arrangements. There are appendices covering: the remit letter and terms of reference for the review; the consultation document; the evidence; salary scales, fees and allowances for consultants; the main features of the consultants' award schemes across the United Kingdom; comparability of consultants' award schemes with other core public sector and NHS contingent pay schemes; a list of previous DDRB reports; a glossary of terms; and abbreviations and acronyms used in this report.

The terms of reference

1.2 The Secretary of State for Health, the Right Honourable Andrew Lansley CBE MP, wrote to the DDRB Chairman on 23 August 2010, on behalf of the United Kingdom Health Ministers to commission a United Kingdom-wide review of compensation levels and incentive systems and the various Clinical Excellence and Distinction Awards schemes for NHS consultants at both national and local levels. A copy of his letter is at Appendix A.

1.3 The terms of reference for the review asked us to look 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, in the context of key government documents. The remit related to compensation levels and incentives and asked us:

- 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; to consider total compensation levels for consultants and make observations (rather than recommendations) on basic pay scales; and
- 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; specifically to reassess the structure of and purpose for the Clinical Excellence and Distinction Awards schemes and provide assurance that any system for the future included a process which was fair, equitable and provided value for money.

1.4 The terms of reference said that the review should be fully linked into other activity on public sector pay including: the benchmarking work on senior public sector pay carried out by the Senior Salaries Review Body; the Fair Pay Review in the public sector led by Will Hutton; and the review of public service pensions by Lord Hutton's Independent Public Service Pensions Committee.

1.5 We were also asked to consider issues of comparability with other public sector and NHS incentive schemes, and told that the recommendations must take full account of affordability and value for money, and must respect the accrued rights of individuals.

The devolved countries

- 1.6 Our remit covers the whole of the United Kingdom, and the award schemes differ in each of the four countries. However, unless we specify that comments are relevant only to England, Wales, Scotland or Northern Ireland, we refer to the whole of the United Kingdom.

The evidence and conduct of the review

- 1.7 A consultation, seeking views for the review, was held between 31 August and 26 November 2010. This was sent to: the four Health Departments of the United Kingdom; the British Medical Association; NHS Employers; the British Dental Association; the Advisory Committee on Clinical Excellence Awards (ACCEA); the Scottish Advisory Committee on Distinction Awards (SACDA); the Northern Ireland Clinical Excellence Awards Committee (NICEAC); the Academy of Medical Royal Colleges; the Association of United Kingdom University Hospitals; the Committee of Postgraduate Dental Deans and Directors; the Conference of Postgraduate Medical Deans of the United Kingdom; the Hospital Consultants and Specialists Association; the Medical Women's Federation; the National Leadership Council; the National Patient Safety Agency; the National Quality Board; and the Universities and Colleges Employers Association. It was also published on the website of the Office of Manpower Economics so that any interested parties could submit their views. A copy of the consultation document is at Appendix B.
- 1.8 We received responses to our consultation from 44 individuals and 78 bodies; these are listed at Appendix C. Many of the evidence providers supplied supplementary evidence in response to other parties' evidence and in response to our requests. All written evidence received for the review may be viewed on the Office of Manpower Economics website.¹
- 1.9 In addition, we heard oral evidence from: the Parliamentary Under Secretary of State for Quality (Lords), Earl Howe; the Deputy First Minister and Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon; the Chief Medical Officer, Professor Dame Sally Davies; the Health Departments; the awarding bodies (ACCEA, SACDA and NICEAC); the Academy of Medical Royal Colleges; the British Medical Association; NHS Employers; and the Universities and Colleges Employers Association.
- 1.10 We are grateful to all who submitted evidence for their time and effort in preparing and presenting evidence to us, both in writing and orally, and for the speed with which they have responded to our numerous questions and requests for supplementary evidence.

The remit group

- 1.11 This review covers NHS consultant doctors and dentists and clinical academics. The consultant grade is the main career grade for doctors and dentists in the hospital and community health services. Consultants are the most senior medical and dental staff in the NHS and have expert knowledge of their specialties. Working either independently or as head of a team, they lead the delivery of NHS services. In 2010, there were 43,649 full-time equivalent consultants (46,111 headcount) in the United Kingdom, accounting for approximately 36 per cent of hospital and community health services medical and

¹ *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants: update.* Available from: http://www.ome.uk.com/DDR_B_CEA_review.aspx

dental staff² (Table 1.1). There were 2,821 headcount clinical academics in the United Kingdom at 31 July 2010.³

Table 1.1: Headcount and full-time equivalent hospital and community health services' consultants and clinical academics in 2010

		England	Scotland	Wales	Northern Ireland	United Kingdom
Consultants	Headcount	37,752	4,746	2,236	1,377	46,111
	FTE	35,781	4,434	2,131	1,302	43,649
Clinical academics	Headcount	2,303	319	140	59	2,821

Sources: NHS Information Centre, ISD Scotland, StatsWales, DHSSPSNI, Medical Schools Council. Hospital and community health services data are as at September 2010 in England, Scotland and Wales, and March 2010 in Northern Ireland. Data on clinical academics are as at July 2010, and include staff at professor, senior lecturer and reader grades.

1.12 New consultant contracts were agreed in 2003 and differ in each of the devolved countries. The contract was optional for individual consultants in England, Scotland and Northern Ireland, although all new appointments or moves to a new trust are under the new contract and fewer than 10 per cent of consultants in these countries remain on the old contract. Following acceptance of the new contract by ballot, consultants in Wales were obliged to transfer to the new contract. All consultants, whatever their type of contract, are now expected to have agreed job plans scheduling both their clinical and non-clinical activity.

1.13 Under the new contract, consultants have to agree the number of Programmed Activities they will work. Each Programmed Activity is four hours, or three hours in 'premium time', which is defined as between 7 p.m. and 7 a.m. during the week, or any time at weekends. In England, Scotland and Northern Ireland, ten Programmed Activities represent a full-time post, but the contract refers only to minimum commitments and does not define a maximum. On average, 7.5 Programmed Activities are for direct clinical care and 2.5 are for Supporting Professional Activities, for example, training, continuing professional development, job planning, appraisal and research, although different patterns can be agreed through the job planning process. The consultant contract for Wales is addressed in paragraph 1.16.

1.14 Total pay is composed of five elements:

- basic pay;
- additional Programmed Activities/Supporting Professional Activities;
- on-call supplements;
- Clinical Excellence Award/Discretionary Point/Distinction Award payments; and
- other fees and allowances.

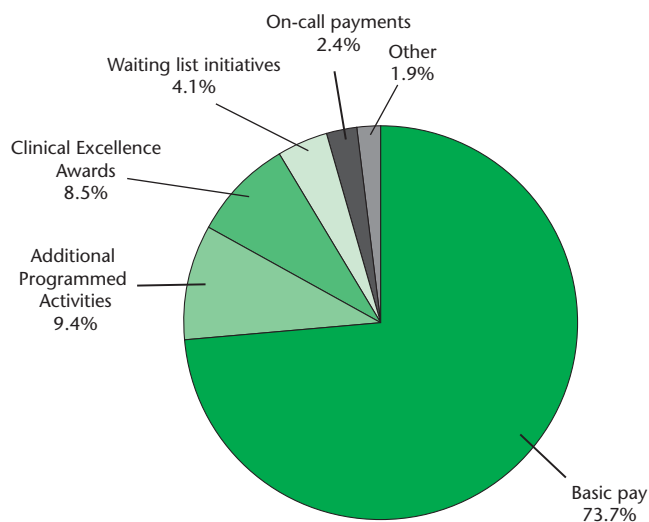
The current levels of payments are at Appendix D.

² Hospital and community health services staff are comprised of: consultants; doctors and dentists in training; speciality doctors and associate specialists; and others (including: hospital practitioners; clinical assistants; and some public health and community medical and dental staff). General medical practitioners, general dental practitioners and ophthalmic medical practitioners are excluded from this category.

³ It is not possible to determine whether or not clinical academics are also counted in the NHS census: we have been told by the NHS Information Centre that practice may vary from employer to employer, and that some or all clinical academics may be counted. For the purposes of our analysis, we have assumed that they are not counted.

1.15 The contribution of pay above basic pay can be significant: in England, the mean basic salary per full-time equivalent consultant was £89,600 in October – December 2010, while the mean total earnings were 32 per cent higher at £118,200.⁴ A detailed breakdown of pay is not available at national level;⁵ as an example, Figure 1.1 below provides a breakdown of the consultant pay bill for 2010-11 for one trust, Nottingham University Hospitals NHS Trust. Basic salaries accounted for around three-quarters of the total pay bill, while Clinical Excellence Awards comprised 8.5 per cent.

Figure 1.1: A breakdown of the consultant pay bill in Nottingham University Hospitals NHS Trust, 2010-11



Source: Nottingham University Hospitals NHS Trust.

Consultants in Wales

1.16 The main differences for the new contract in Wales are: a basic 37.5 hour working week (compared to 40 hours in England); a system of Commitment Awards; and a slightly different salary structure. Commitment Awards replaced the former Discretionary Points scheme. There are a total of eight Commitment Awards and they are paid every three years after reaching the new maximum of the pay scale (see Appendix D). Consultants in Wales are also eligible for national level Clinical Excellence Awards.

Clinical academics

1.17 Clinical academics are doctors or dentists who are employed by Higher Education Institutions, or other organisations, in a research and/or teaching capacity and who also provide services for NHS patients. The group is comprised of consultant clinical academics and senior academic general medical practitioners holding honorary NHS contracts.

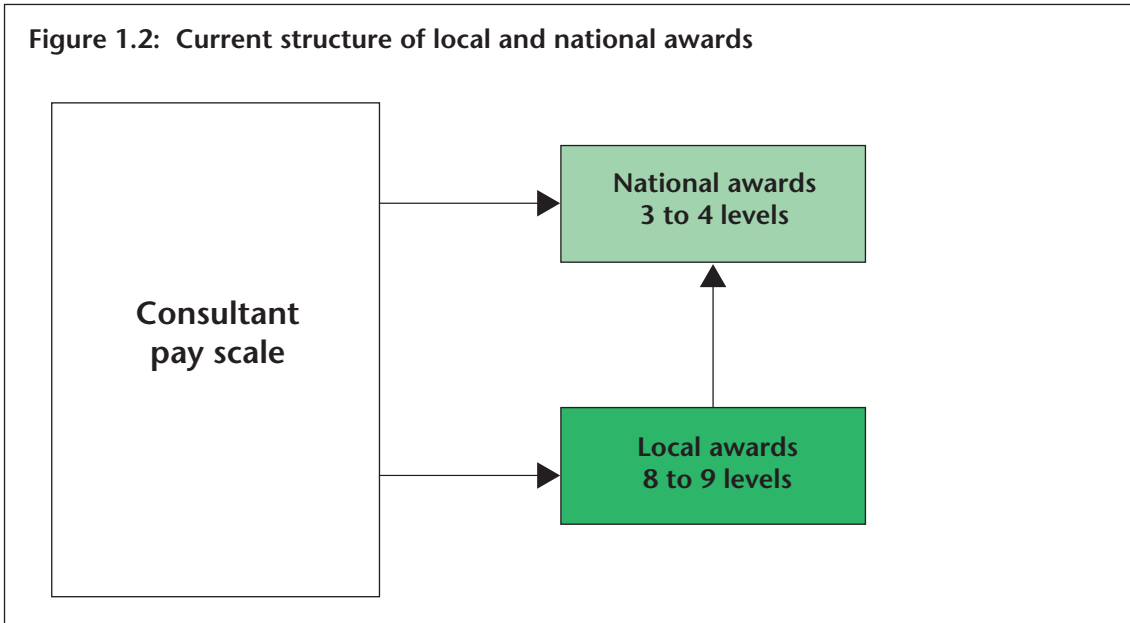
1.18 Clinical academics' salaries are paid by the universities; they are based on parity with the NHS and thus linked to the NHS consultants' pay scale.⁶ DDRB recommendations on pay uplifts do not apply to clinical academics; it is the Clinical Academic Staff Sub-Committee of the Joint Negotiation Committee for Higher Education Staff that

⁴ NHS Information Centre Staff Earnings Estimates, October to December 2010. Data are for consultants on the 2003 contract. Available from: <http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-earnings/nhs-staff-earnings-october--december-2010>

⁵ This is a limitation of the data warehouse for the Electronic Staff Record Human Resources system used by nearly all trusts in England: data on basic salary and total earnings are all that is available.

⁶ Universities and College Employers Association. *Clinical academic pay scales (England) from 1 April 2010*. UCEA update 10:052: Appendix A, section 3. Available from: <http://www.kent.ac.uk/hr-staffinformation/documents/salary/Clinical-academic-salary-scales.pdf>

Figure 1.2: Current structure of local and national awards



1.22 The proportion of consultants holding local awards in each of the four countries ranges from 36.8 per cent to 47.9 per cent, with the proportion holding national awards ranging from 7.0 per cent to 11.4 per cent (Table 1.2). In the United Kingdom as a whole, just over half of consultants and clinical academics held a local or national award in 2010.

Table 1.2: Awards held by consultants and clinical academics, 2010

		England	Scotland	Wales	Northern Ireland	United Kingdom
Local awards ⁽¹⁾	Number	15,992	2,099	1,137	529	19,757
	Per cent	39.9%	41.4%	47.9%	36.8%	40.4%
	Average value £	12,485	12,016	8,659	9,743	12,143
National awards ⁽²⁾	Number	3,868	578	210	100	4,756
	Per cent	9.7%	11.4%	8.8%	7.0%	9.7%
	Average value £	43,194	42,870	41,841	43,752	43,107
No award	Number	20,195	2,388	1,029	807	24,419
	Per cent	50.4%	47.1%	43.3%	56.2%	49.9%
Consultant population ⁽³⁾	Number	40,055	5,065	2,376	1,436	48,932
	Per cent	100%	100%	100%	100%	100%

Data on the number of awards in payment were provided by ACCEA, SACDA, WAG and DHSSPSNI.

Data on the hospital and community health services consultant population were obtained from the NHS Information Centre, SGHD, WAG and DHSSPSNI.

⁽¹⁾ Local awards include local Clinical Excellence Awards, Discretionary Points and Commitment Awards.

⁽²⁾ National awards include national Clinical Excellence Awards and Distinction Awards.

⁽³⁾ NHS hospital and community health service consultants plus clinical academics with honorary NHS contracts.

1.23 In the United Kingdom as a whole, over £500 million was spent on awards to consultants and clinical academics in 2009-10, which accounted for between 5.9 per cent and 9.7 per cent of the total pay bill for consultants in each country (Table 1.3).

Table 1.3: Cost of awards, 2009-10

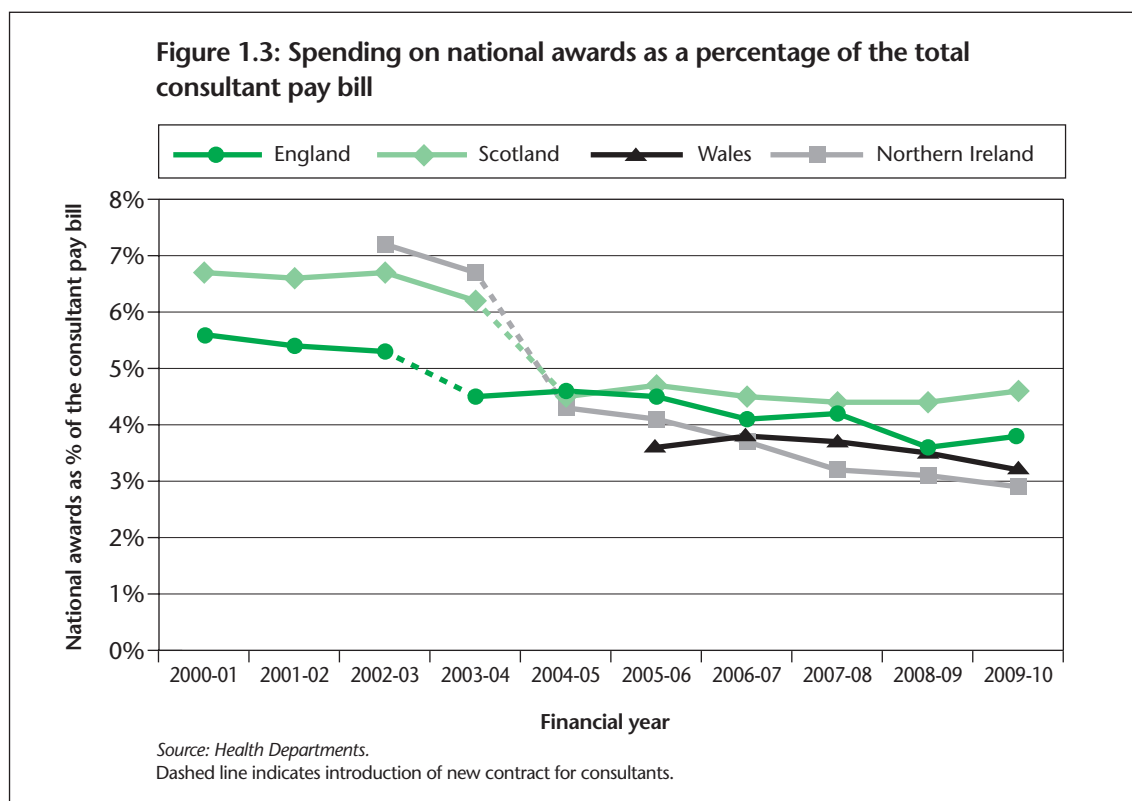
	England		Scotland		Wales		Northern Ireland		United Kingdom	
	£m	% ⁽¹⁾	£m	% ⁽¹⁾	£m	% ⁽¹⁾	£m	% ⁽¹⁾	£m	% ⁽¹⁾
Local awards	225	4.2	31	5.1	9	2.7	7	3.4	272	4.2
National awards	202	3.8	28	4.6	11	3.2	6	2.9	247	3.8
Total	427	7.9	59	9.7	20	5.9	13	6.3	518	7.9

⁽¹⁾ Percentage of the total NHS consultant pay bill (including employers' pension and National Insurance contributions). This excludes the pay bill for clinical academics, and is therefore an overestimate.

Individual items may not sum to totals due to rounding.

Sources: Written evidence from the Health Departments.

1.24 Figure 1.3 shows the cost of national awards as a percentage of the consultant pay bill in each country since 2000-01.⁸ The introduction of the new consultant contract led to large increases in the consultant pay bill per full-time equivalent consultant,⁹ while the increase in spending on national awards was more modest, leading to a reduction in the proportion of the pay bill spent on national awards.¹⁰ The cost of national awards as a percentage of the pay bill has been fairly steady since 2004-05.



⁸ Historical data on the cost of local awards are not available for all countries.

⁹ The increase in the NHS consultant pay bill per full-time equivalent in England was 12.4 per cent between 2002-03 and 2003-04; in Scotland, 49.0 per cent between 2003-04 and 2004-05; and in Northern Ireland, 29.6 per cent between 2003-04 and 2004-05.

¹⁰ The increase in spending on national awards in England was 3.7 per cent between 2002-03 and 2003-04; in Scotland, 8.9 per cent between 2003-04 and 2004-05; and in Northern Ireland, minus 13.7 per cent between 2003-04 and 2004-05.

CHAPTER 2 – THE HISTORY AND PURPOSE OF THE AWARDS SYSTEM

- 2.1 In this chapter, we set out our understanding of the historical background to the creation of the awards system and describe its purpose. This is to enable us, as required by the terms of reference¹ for the review, to reassess the structure and purpose of the awards schemes. Appendix E contains a comparative table of the consultants' award schemes across the United Kingdom. We are grateful to the Advisory Committee on Clinical Excellence Awards (ACCEA), and in particular the research carried out by Dr Anton Joseph, as well as the information provided by the British Medical Association from which we have drawn heavily in writing this section. The full versions of the evidence we received are available online (see Appendix C).
- 2.2 Schemes to provide consultants with some form of financial reward for exceptional achievements and contributions to patient care have been in existence since the beginning of the NHS in 1948. Many doctors were in possession of a lucrative practice and were fearful of losing their income and were strongly opposed to the formation of the NHS. Aneurin Bevan and Lord Moran, President of the Royal College of Physicians, were said to have enunciated the concept of an awards scheme to allay the concern of those who feared a loss of income, and to attract and persuade the specialists who through their reputation were influential in their profession.

1948 Spens Report²

- 2.3 The terms of reference of the Spens committee were:

“To consider after obtaining whatever information and evidence we thought fit, what ought to be the range of total professional remuneration of registered medical practitioners engaged in the different branches of consultant or specialist practice in any publicly organised hospital and specialist service; to consider this with due regard to what have been the financial expectations of consultants and specialist practice in the past, to the financial expectations in other branches of medical practice, to the necessary post graduate training and qualifications required and to the desirability of maintaining the proper social and economic status of specialist practice and its power to attract a suitable type of recruit, having regard to other forms of medical practice; and to make recommendations.”

- 2.4 The terms of reference implied that the differential in the income between different specialist branches should be maintained. The committee observed:

“We were instructed in our remit to have due regard to what had been the normal financial expectations of consultants and specialist practice in the past. We considered very carefully at the outset to what extent the income of consultants in the publicly organised service of the future should be related to past incomes which had been derived mainly from private practice, and we decided that in accordance with our remit we were bound to have regard to past remuneration from all sources in judging what effect our recommendations were likely to have upon the recruitment of medical practitioners to the consultant ranks.”

¹ The terms of reference for the review are given in Appendix A.

² Sir Will Spens (chairman). *Report of the Interdepartmental Committee on the Remuneration of Consultants and Specialists*. Cmd. 7420. HMSO, 1948. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2090814/pdf/brmedj03733-0030.pdf>

- 2.5 The Spens committee decided not only to accommodate differential income of individuals joining the NHS but accepted the importance of some specialties more than others:

“Thus the highest remuneration would be open to specialists in all fields although the proportion attaining that remuneration might be less in some fields than in others and might vary with the increasing importance of this or that branch of medicine.”

- 2.6 The Spens committee also warned:

“whilst it would in our view be impracticable to distribute these distinctions on the basis of a specified quota for each hospital region, they should not be allowed to gravitate towards a few large teaching hospital centres; and we wish to stress that...regard should be had to the desirability of spreading such awards over the country as well as over different branches of specialist practice.”

- 2.7 The need for attracting the best to serve in the NHS in order to maintain its position as a world leader was clearly expressed in the report. The level of award was to enable a significant minority to be remunerated at the highest levels available to other professions:

“...we would emphasise that if the best possible recruits are to be attracted to specialist practice, there must remain for a significant minority the opportunity to earn incomes comparable with the highest which can be earned in other professions...There is a further point to which we attach great importance. We are convinced that the remuneration offered to specialists of exceptional ability must be sufficient not only to attract the most able specialists of this country to the public service, but to maintain the position of British medicine in a competitive market which includes the Dominions and the United States of America.”

- 2.8 The Spens committee recommended three levels of award: £2,500, £1,500 and £500, each being awarded to 4 per cent, 10 per cent and 20 per cent of the eligible consultants respectively. It recommended the creation of a body and a special machinery to select the individual specialists whose outstanding distinction merited additional rewards. This was to be a mainly professional body whose proceedings were to be secret, with the professional members nominated by the Royal Colleges. Recipients of awards were not published, even in the medical press. The implementation of the scheme without strict procedures or criteria for nominating consultants for awards did little to enhance the credibility of the scheme: the Spens committee was thought to have granted unlimited discretionary powers to the National Committee, which

“consisting in the main of eminent members of the profession who from their own knowledge or otherwise would be able to reach an authoritative opinion on the comparative merits of the candidates.”

- 2.9 Over the next few years, criticisms were levelled against the awards system by the public, cabinet members, Members of Parliament from all sides of the House and professionals, largely on account of its secrecy, the greater number of awards granted to certain specialties and even discrimination against certain specialties, geographical differences and recognition of a hierarchy of hospital types.

*1957-60 Royal Commission on Doctors' and Dentists' Remuneration (the Pilkington Commission)*³

- 2.10 The awards system was reviewed by the Pilkington Commission in 1957. Since a medical practitioner was not able to vary their fees based on their level of professional competence and standing and promotions in recognition of their ability was not an option, the Pilkington Commission said:

“In these circumstances we consider the awards system is a practical and imaginative way of securing a reasonable differentiation of income and of providing relatively high earnings for the ‘significant minority’ to which the Spens Committee referred. We therefore unreservedly support the continuation of the system.”

- 2.11 Changes recommended by Pilkington included the establishment of Regional Awards Committees to make recommendations for C awards and the creation of the A+ awards, the highest awards in the scheme.

*1979 Royal Commission on National Health Service*⁴

- 2.12 The Royal Commission agreed with the Pilkington Commission on the reasons to continue with the awards system. The main criticisms made to the Royal Commission were: that the awards did not always reflect hard work which benefited the NHS and that the failure to publish the names of the award holders was undesirable. The Commission was therefore pleased to note the agreement between the profession and the health departments to relax the secrecy, thereby permitting access to the nominal roll of consultants holding awards. It stated:

“that the possession or otherwise of a Distinction Award might mislead the public about the relative merits of consultants, but this danger does not seem to us a very serious one compared with the suspicions engendered by wrapping the whole process in secrecy.”

- 2.13 The Royal Commission also recommended greater input from health authorities so that the “consultant who carries the heat and burden of the day should more readily receive recognition.”

*1985 Comptroller and Auditor General review*⁵

- 2.14 This report drew attention to the wide variation in the distribution of awards between specialties, although it commented on some evidence of equalisation during the few years preceding the report. The Department of Health and Social Security explanation was that this “may be partly due to the age structure of the different specialties”.
- 2.15 The Comptroller and Auditor General concluded that they too expressed satisfaction with the scheme as stated in previous reports.

*1988 Report of the Review Body on Doctors' and Dentists' Remuneration*⁶

- 2.16 Our own 1988 Report identified a number of potential concerns with the scheme: that awards were being given to individuals on the point of, or even after, retirement; that there was no provision to remove awards from holders whose performance noticeably

³ Sir Harry Pilkington (chairman). *Royal Commission on Doctors' and Dentists' Remuneration 1957-1960*. Cmnd 939. HMSO, 1960.

⁴ Royal Commission on the National Health Service. *Report of the Royal Commission*. Cmnd 7615. HMSO, 1979.

⁵ Report of the Comptroller and Auditor General. *National Health Service: hospital based medical manpower*. Cmnd 373. HMSO, 1985.

⁶ Review Body on Doctors' and Dentists' Remuneration. *Eighteenth Report*. Cm 358. HMSO, 1988.

declined; and noted that “we have heard that doctors and other interested parties are not convinced that all the best candidates are identified for awards or that awards are always apportioned fairly by age, gender, specialty and region”. The Review Body therefore urged the parties to consider whether the scheme could be improved.

1989 White Paper – Working for patients⁷

- 2.17 The 1989 White Paper stated that the government “recognises the value of Distinction Awards in rewarding professional excellence and therefore proposes that all consultants employed by self-governing hospitals should be eligible for awards”.
- 2.18 Recommendations included: the criteria for C awards should reflect the consultant’s clinical skills and their contribution and commitment to the development and management of the service; higher awards were to be available only to those who already had C awards; the C award committees were to include senior managers as well as clinicians; awards were to be reviewed every five years; and new awards were to be pensionable only if the consultant continued to work in the NHS for at least three years.

1994 Report of a working party on the Review of the consultants’ Distinction Awards scheme – the Kendell Report⁸

- 2.19 This report was considered an important landmark in the evolution of the awards scheme, and included a summary of the working of the scheme at the time. It noted that the Advisory Committee on Distinction Awards (ACDA) had 25 members, mainly drawn from the Royal Colleges and faculties, universities, the Medical Research Council, the general body of consultants and the chief executive of the NHS Management Executive. The chairman was usually a senior consultant, the vice chairman a lay appointee, a retired senior public servant.
- 2.20 In announcing the review of the Distinction Awards scheme, Ministers had indicated their intention to modify the leadership of the ACDA, with a lay chairman representing employers and a medical director to deal with the day-to-day operation of the scheme. Despite this, the working party “saw no reason to change the professional composition of the ACDA”.
- 2.21 In its report, the working party was puzzled by the fact that “there were no formal criteria for awards”. It also noted that in the guidance to awards committees, “there was no requirement to record the discussion about, or the reasons for award recommendations being made at either regional or national level”.
- 2.22 Having debated the issue of performance-related pay, the report concluded that Distinction Awards “can themselves rightly be regarded as a form of performance-related pay”. It was decided to improve the existing Distinction Awards and to provide a means for NHS trusts and other employers to have a greater role in determining remuneration for a “crucially important group of their staff”.
- 2.23 The report recommended the creation of local and national awards: local awards should be a means of rewarding outstanding professional work of direct benefit to patient care in the local hospital or community; and national awards should be a means of rewarding outstanding professional work of wider benefit to patients in the NHS as a whole. The local awards replaced the C awards. Local and national awards were to be parts of a unitary scheme, the intention being that consultants would “earn their spurs locally” before proceeding to the national awards.

⁷ Department of Health. *Working for patients*. Cm 555. HMSO, 1989.

⁸ R. Kendell (chairman). *Report of the working party on the review of the consultants’ Distinction Awards scheme*. EL(94)99. NHS Executive, 1994.

2.24 In the event, local awards were not created and instead the Discretionary Points scheme was introduced, which extended the consultants' salary scale range by five roughly equal steps. The number of levels was subsequently increased to eight. Discretionary Points were decided under separate arrangements from Distinction Awards. Distinction Awards were the B, A and A+ awards. Consultants were not required to hold the maximum Discretionary Points (or any Discretionary Points) before being eligible for Distinction Awards.

England and Wales

*February 2001: Rewarding commitment and excellence in the NHS, Consultation document. Proposals for a new consultant reward scheme – Clinical Excellence Awards*⁹

2.25 The next major review was carried out in 2001 as part of the introduction of the new consultant contract planned for implementation in 2002. The consultation document set out proposals to replace the Discretionary Points and Distinction Award schemes with a single scheme comprising both local (employer-based) and national elements. The scheme eventually came into operation in 2004-05.

2.26 Changes in the scheme were in response to sustained criticisms of the wide discrepancies between the various specialties and, in particular, between consultants in the teaching and the major hospitals and the non-academic and smaller district general hospitals. Alleged discrimination against ethnic minorities led to investigations by the Commission for Racial Equality in 1997 and the conclusions also informed the recommendations in the consultation document.

2.27 Under the new title of Clinical Excellence Awards, the new scheme aimed to reward consultants who contributed most towards the delivery of safe and high quality care to patients, and were continuously improving the quality of their services to patients and to the NHS. This new approach intended to reward consultants making the most contribution to the NHS through direct patient care or through contributions to academic medicine. Contributions might be at local, national or international levels. Contributions over and above contractual responsibilities and requirements were to be rewarded. There are five domains in which applicants can detail their achievements:

- delivering a high quality service;
- developing a high quality service;
- leadership and managing a high quality service;
- research and innovation; and
- teaching and training.

2.28 There are 12 levels of award. In England, levels 1 to 8 are awarded locally (employer-based awards) and levels 10 to 12 (silver, gold and platinum) replaced the B, A and A+ awards and are awarded nationally in England and Wales. Level 9 awards in England can be awarded locally as employer-based awards or nationally as a bronze award, depending on the type of contribution. National awards and local level 9 awards are reviewed every five years. In Wales, there are no local awards: instead, Commitment Awards are made by employers every three years (subject to satisfactory annual appraisals) once the maximum point of the pay scale has been reached. Consultants who are successful in applying for

⁹ *Rewarding commitment and excellence in the NHS: consultation document – proposals for a new consultant award scheme.* Department of Health, 2001.

national Clinical Excellence Awards lose any Commitment Awards they have accumulated previously.

- 2.29 In contrast to the Discretionary Points and Distinction Award schemes, the criteria for Clinical Excellence Awards are common to both the local and national awards, with the level of the award being determined by the extent of the contributions. As with the earlier schemes, it is not necessary to reach the top of the local awards to proceed to the national awards.
- 2.30 ACCEA, a non-departmental public body, administers the scheme. ACCEA and its sub-committees recommend individuals for bronze, silver, gold and platinum awards. Applicants for levels 1 to 9 are made by employer-based awards committees. ACCEA monitors the employer-based scheme in England.
- 2.31 ACCEA issues operational guidelines and is responsible for issuing criteria for the awards. It advises Ministers on nominations for national awards based on the extensive consultations carried out by its chair and medical director with the thirteen regional ACCEA sub-committees, and takes into account the advice and recommendations from the national nominating bodies and others. An employer citation is a prerequisite for consideration for an award.

2008 The Next Stage Review – Darzi Review¹⁰

- 2.32 The Darzi Review considered the role of Clinical Excellence Awards and proposed to strengthen the scheme, making awards and renewals “more conditional on clinical activity and quality indicators” and to “encourage and support clinical leadership”. It proposed that the transparency of the scheme should be increased, with applications being publicly available. The profession was to be involved in developing these changes, and ACCEA was to have regard to advice from the National Quality Board and NHS Leadership Council.

Scotland

Distinction Awards

- 2.33 Following consultation with a wide range of professional and employer bodies early in 1998, Scottish Ministers decided to establish a separate Scottish Advisory Committee on Distinction Awards (SACDA) to replace the existing Scottish Subcommittee of the United Kingdom committee and take responsibility for decisions on all consultants’ Distinction Awards in Scotland. However, the principle of there being broad consistency in the underlying principles and operation of the schemes between countries continued to be applied. At that time, a number of changes were made to ensure fairness, greater transparency of the process, better recognition of service goals and the option for SACDA to review and, if necessary, withdraw awards. The scheme was also extended to include academic general medical practitioners.
- 2.34 SACDA is a non-departmental public body which acts on behalf of the Deputy First Minister and Cabinet Secretary for Health and Wellbeing in deciding which consultants in NHS Scotland (including clinical academics) should be granted Distinction Awards. This is done using a system based on peer review, employer and lay input and the evidence submitted by the consultant. Distinction Awards are funded centrally by the Scottish Government. 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

¹⁰Professor the Lord Darzi of Denham. *High quality care for all: NHS Next Stage Review final report*. Cm 7432. Department of Health, 2008. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

level Distinction Award previously held. Discretionary Points and Distinction Awards are separate schemes with payments decided under separate arrangements.

2.35 All applications are assessed against the same criteria and scored by SACDA according to its guidelines. The criteria apply to all levels of award, but take account of the achievements possible at different stages of a career. The criteria are:

- 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.

2.36 Since 1989, awards granted are subject to five-yearly review to ensure the holder continues to meet the criteria.

Discretionary Points

2.37 Discretionary Points replaced the C Distinction Award, and are awarded to consultants (including clinical academics) for work which demonstrates an above-average contribution in respect of service to patients, teaching, research, and the management and development of the service.

2.38 Decisions on who receives Discretionary Points are made by the local employer on the advice of a Discretionary Points Committee which includes employer and professional members. Points are funded by employing authorities from their general allocations. Discretionary Points are consolidated payments in addition to the maximum of the consultant salary scale. The Discretionary Point scale consists of eight points which are pensionable and are retained by an individual should they move to another NHS employer. Part-time consultants and clinical academics undertaking less than five Programmed Activities a week for the NHS are awarded Discretionary Points on a *pro rata* basis.

The proposed Scottish Consultants Clinical Leadership and Excellence Awards Scheme

2.39 During the negotiations on the 2003 consultant contract for Scotland (which also covered consultant clinical academics), it was agreed between the then Scottish Executive Health Department and the British Medical Association Scotland that, following the completion of those talks, a fundamental review should be undertaken of the Distinction Awards and Discretionary Points schemes in Scotland, with a view to their replacement. The review did not, however, begin until late 2006. It was undertaken by a Review Group chaired by the Chief Medical Officer and comprising members drawn from NHS Scotland employers, SACDA, the Scottish Joint Consultants Committee and the Chief Scientist for Scotland. The group recommended a framework for a replacement scheme to the Scottish Government in early 2009, and it was approved by the Cabinet Secretary for Health and Wellbeing in August 2009.

2.40 The proposed new scheme would comprise 13 continuous points: 1 to 10 to be administered by NHS Scotland boards; and 11 to 13 to be the responsibility of the Scottish Advisory Committee on Consultants' Clinical Leadership and Excellence Awards (SACCCLEA), to replace SACDA.

2.41 Awards would be made for outstanding performance over and above what would be contractually required. The criteria for awards would be linked to service goals and be concerned with rewarding excellence and not the contracted time devoted to specific activities. There would be six domains, although it would not be expected that a consultant would need to demonstrate outstanding achievement in all of these domains in order to achieve an award. Achievement would be measured within the parameters of each consultant's job plan and available opportunities. The domains would be:

- scope and level of professional contribution to the NHS;
- audit, clinical governance, promotion of evidence-based medicine;
- administrative, management and advisory activities;
- research and innovation;
- teaching and training; and
- improvements in service and achievement of service goals.

2.42 Awards would be paid with salaries, be pensionable and subsume the value of any existing Discretionary Points, Distinction Awards or lower level Clinical Leadership and Excellence Award held. The intention was that national level 11 to 13 awards would be subject to review to ensure that standards for which awards were granted were maintained. SACCCLEA might remove or downgrade an award if appropriate.

2.43 The new scheme was intended to promote equality of access to awards and promote fairness and transparency in the operation of the scheme and consistency across Scotland. This would be achieved by:

- a greater role for employers in deciding level 9 and 10 local awards;
- a role for SACCCLEA in supporting local awards by providing a framework for governance and national reporting;
- the same application and scoring system to be used for local and national awards;
- all applications to be solely by self-nomination through an on-line application process;
- SACCCLEA would monitor the geographical spread of all levels of awards, as well as the distribution between specialties, genders and ethnic minorities. It would work to ensure that the interests of consultants in groups with a relatively low proportion of awards, and those working in special and unusual situations, would be carefully considered; and
- local awards committees would have to demonstrate to SACCCLEA that there was an appropriate and auditable approach to decision making. This would be done through the submission of a standardised local awards committee report at the end of each awards round.

2.44 *Implementation of the new scheme was put on hold while we carried out this review. We note the British Medical Association's comment that as the new scheme had not been introduced, it was difficult to see how it could be reviewed or judged.*

Northern Ireland

- 2.45 The current consultant contact was introduced in Northern Ireland in 2004, followed by the Northern Ireland Clinical Excellence Award scheme in 2005. The Northern Ireland Clinical Excellence Award scheme was largely modelled on the Clinical Excellence Award scheme for England, but with some differences:
- applications for awards are by self-nomination (including clinical academics);
 - consultants are only able to apply for their first Clinical Excellence Award after they have been a consultant for three years; and
 - consultants are only eligible to apply for a higher-level Clinical Excellence Award (steps 10 to 12) after obtaining at least four lower level Clinical Excellence Awards.
- 2.46 Step 1 to 9 awards are granted by local awards committees set up by employers, consisting of management representatives and only higher award holders. No lower award holders are permitted to sit on these committees. Step 10 to 12 awards are granted by a regional process conducted by the Northern Ireland Clinical Excellence Awards Committee (NICEAC).
- 2.47 In 2008, the Department of Health, Social Services and Public Safety in Northern Ireland commenced a review of the Clinical Excellence Award scheme which particularly focused on the funding of the scheme. After an extended period of consultation with various stakeholders including the British Medical Association and employers, the review group produced a report recommending:
- a ratio of local awards to eligible holders of 0.25;
 - moving the step 9 award from local distribution to regional distribution by NICEAC; and
 - preventing eligible consultants from applying for both a higher and lower Clinical Excellence Award in the same year.

CHAPTER 3 – OTHER PUBLIC SECTOR AND NHS INCENTIVE SCHEMES

- 3.1 In this chapter, we consider issues of comparability with incentive schemes elsewhere in the NHS and the wider public sector as required by the terms of reference¹ for the review. For the purposes of this chapter, we have looked at incentive schemes in the broadest sense of contingent pay, i.e. financial rewards in addition to base pay that are related to performance, competence, skill and/or experience.² We use a narrow definition of performance-related pay in this chapter, i.e. as a subset of contingent pay.
- 3.2 In this chapter we address the following types of contingent pay,³ recognising that the boundaries between the different categories are sometimes blurred:
- individual performance-related pay;
 - bonuses;
 - incentives;
 - incremental pay linked to performance;
 - competence-related pay (including skill-based pay); and
 - contribution-related pay.
- 3.3 The table at Appendix F provides examples of where each of these categories of contingent pay may be found in the NHS and the core public sector. Most categories of staff in the core public sector receive some form of contingent pay, with the exception of judges⁴ and Members of Parliament.

Individual performance-related pay

- 3.4 Under individual performance-related pay, increases in base pay and/or cash bonuses are determined by performance assessment and ratings. Individual performance-related pay is used for some NHS Very Senior Managers,⁵ the Civil Service, senior officers in the Armed Forces and senior police officers. Appendix F contains examples of the use of individual performance-related pay across the core public sector.

Bonuses

- 3.5 Bonuses are rewards for successful performance paid as cash lump-sums related to the results obtained by individuals, teams or business performance; they are not consolidated into basic pay and are generally not pensionable. They are widely used in the United Kingdom, especially in the private sector. Over the past two years, the media has frequently referred to the consultant award schemes as 'bonuses', although many of the respondents to our consultation were at pains to point out that these awards were not bonuses.

¹ The full terms of reference for the review are given in Appendix A.

² Contingent pay is often referred to as variable pay or pay-at-risk if the payments are not consolidated into base pay

³ The definitions have been based on those found in: Michael Armstrong. *Employee reward*. 3rd ed. Chartered Institute of Personnel and Development, 2002.

⁴ Contingent pay is perceived to run counter to the constitutional position and judicial independence.

⁵ NHS Very Senior Managers in England are chief executives, executive directors (except medical directors), and other senior managers with board-level responsibility who report directly to the chief executive, in: Strategic Health Authorities, Special Health Authorities, Primary Care Trusts and Ambulance Trusts.

- 3.6 The British Association of Stroke Physicians argued for the removal of the term ‘bonus’ from the public debate on consultants’ award schemes; it believed that the use of this term implied that awards were unearned income poorly linked to performance. It said that the highly competitive nature of the award structure ensured that the NHS benefited from a great deal more added value from applicants than it had to pay through the scheme.
- 3.7 *We do not consider Clinical Excellence Awards, Distinction Awards and Discretionary Points to be bonuses; they are consolidated payments that reward past performance and we see them as a form of contribution pay, as explained later in this chapter.*
- 3.8 The Chartered Institute of Personnel and Development annual reward survey for 2011⁶ found that 70 per cent of respondents used a cash-based bonus or incentive plan, although this figure varied widely between individual sectors:
- manufacturing and production – 91%
 - private sector services – 81%
 - public services – 38%
 - voluntary, community and not-for-profit – 27%
- 3.9 Examples of bonus schemes can be found for some NHS Very Senior Managers, the Civil Service, the higher levels of the Prison Service and police, and some senior executives in local government. The size of these bonuses tends to be small in comparison with the private sector, for example, up to a maximum of 15 per cent of salary for chief constables. We note that for NHS Very Senior Managers, regardless of individual performance, no bonus is payable if the organisation does not achieve its financial targets. Appendix F provides examples of the use of bonuses across the core public sector.

Incentives

- 3.10 Incentives are payments linked to the achievement of previously set targets that are designed to motivate people to achieve higher levels of performance; the targets are usually quantified in terms of output or sales. Examples of such schemes can be found in the Quality and Outcomes Framework for general medical practitioners and the Personal Dental Services Plus contract for general dental practitioners. Appendix F provides examples of the use of incentives across the core public sector.

Incremental pay linked to performance

- 3.11 Incremental pay is defined as increases by fixed increments on a scale or pay spine depending on service in the job; there may be scope for varying the rate of progress up the scale according to performance, which for the purposes of this chapter is the most relevant form. This is the traditional form of contingent pay widely used in the public sector though it is now less common in the private sector. Examples can be found in the NHS, Civil Service, Armed Forces, Prison Service, teachers, police, local government, further education colleges and universities. In most cases across the core public sector, including hospital doctors and dentists, the increments are subject to satisfactory performance; in practice, we understand that few fail to meet the mark. Appendix F provides examples of the use of increments across the core public sector.

⁶ Chartered Institute of Personnel and Development. *Reward management: annual survey report*. CIPD, 2011: 22. Available from: <http://www.cipd.co.uk/binaries/Reward%20management%202011.pdf>

Competence-related pay (including skill-based pay)

- 3.12 Competence-related pay varies according to the level of competence/skill achieved by the individual. It is a method of rewarding people for their ability in their present and future roles, and is particularly appropriate for knowledge workers and professional staff where skills and behaviours are important. Examples can be found in the NHS, Civil Service, Armed Forces, teachers, police, fire service, further education colleges and universities. Further information can be found in Appendix F.
- 3.13 Skill-based pay, sometimes known as knowledge-based pay, varies according to the level of skill the individual achieves. It was originally used in manufacturing firms but is now used in other service industries and is the equivalent of competence-related pay in these sectors. These categories have been merged for the purposes of this report.
- 3.14 Elsewhere in the NHS, non-medical staff are paid under *Agenda for Change*, which includes an incremental scale with some time-related increments and other increments through gateways linked to competence (the Knowledge and Skills Framework). The Knowledge and Skills Framework was designed to facilitate career progression and provides an outline of the knowledge and skills necessary for each post. We note from Incomes Data Services⁷ that the framework has been criticised by both managers and staff for being over-bureaucratic and time-consuming and in consequence has been underused, which has led to its relaunch. The NHS Pay Review Body (NHSPRB)⁸ has commented extensively on its concerns regarding progress implementing the framework, particularly urging the Health Departments and the Staff Side to give it priority and expressing concern at the low level of staff appraisals which, in NHSPRB's view, needs to be significantly higher to ensure the framework plays its intended role in the *Agenda for Change* structure.
- 3.15 In schools, experienced classroom teachers who have been at the top of the upper spine for a minimum of two years are eligible to apply for Excellent Teacher status.⁹ Those assessed as "excellent" are allocated a spot salary from a pay range for Excellent Teachers (where an Excellent Teacher post has been created in the school). There is also a separate pay spine for Advanced Skills Teachers who act as mentors to other teachers and are expected to spend 20 per cent of their time spreading good practice in other schools.¹⁰

Contribution-related pay

- 3.16 Contribution-related pay relates pay to both outputs (performance) and inputs (competence). It is concerned with how results are achieved as well as the results themselves and means paying for results, plus competence and past performance as well as future success; Clinical Excellence Awards, Distinction Awards and Discretionary Points are a form of contribution-related pay.
- 3.17 Consultants in the Armed Forces have a similar system of Clinical Excellence Awards/ Distinction Awards equivalent to the national awards in the NHS. The scheme is based on the NHS scheme, but the values of awards are lower than in the NHS. There are no local awards and the awards are not pensionable within the Armed Forces Pension Scheme.
- 3.18 Further examples of contribution-related pay can be found in NHS Very Senior Managers, teachers, police and universities; Appendix F contains additional information on the use of contribution-related pay across the core public sector.

⁷ *Pay in the public services 2011: the challenge for reward*. Incomes Data Services, March 2011: 122-123.

⁸ NHS Pay Review Body. *Twenty-Fifth Report 2011*. Cm 8029. TSO, 2011: paras. 5.37-5.38.

⁹ *Pay in the public services 2011: the challenge for reward*. Incomes Data Services, March 2011: 144.

¹⁰ *Pay in the public services: review of 2009, prospects for 2010*. Incomes Data Services, March 2010: 171.

Recognition schemes

3.19 Recognition schemes can be effective in improving employee engagement; they incorporate wider elements of the total reward package, including benefits, learning and development, and the work environment. Recognition is a powerful motivator and recognition schemes aim to publicly acknowledge and reward success. Rewards may be in the form of 'applause' for achievement, for example 'employee of the year', or as gifts, vouchers, holidays and the like. It is worth noting from the Chartered Institute of Personnel and Development annual reward survey for 2011¹¹ that individual non-monetary recognition awards were more common in manufacturing and production (36 per cent) and private sector services (30 per cent) than in public services (17 per cent). By occupational group, such awards were most commonly made to clerical and manual staff (34 per cent), closely followed by technical and professional staff (32 per cent).

Conclusions

3.20 *We have given a great deal of thought to the most appropriate contingent pay scheme for consultants, but have concluded from these comparisons across the NHS and other core public sector schemes that there are not any other types of award schemes that would appear to be a satisfactory model to apply to consultants. Our recommendations in the following chapters are for awards to be non-consolidated and payable for fixed periods of time, which we consider to be a more appropriate form of contingent pay than the current system of awards, which are consolidated and permanent.*

¹¹ Chartered Institute of Personnel and Development. *Reward management: annual survey report*. CIPD, 2011: 23. Available from: <http://www.cipd.co.uk/binaries/Reward%20management%202011.pdf>

CHAPTER 4 – COMPENSATION LEVELS AND INCENTIVES

4.1 In this chapter, we consider compensation levels and incentives in the context of the terms of reference¹ for the review. We are required to consider the need for compensation levels above the basic pay scales for NHS consultants, in order to recruit, retain and motivate the necessary supply of consultants in the context of the international job market and maintain a comprehensive and universal provision of consultants across the NHS. The review is also required to consider total compensation levels for consultants and may make observations, rather than recommendations, on basic pay scales. We are required 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.

Evidence

4.2 The evidence linking compensation for consultants, and awards in particular, to outcomes, either in terms of quality of care or in terms of recruitment, retention and motivation, is limited. When looking for a causal connection, the evidence is particularly scarce. None of the parties submitting evidence had been able to measure the impact of local or national award schemes; see later in this chapter for a discussion of the academic work in this area.

4.3 The majority of submissions did, however, stress the importance of award schemes, which may reflect the fact that most submissions came from the medical profession. The schemes were reported to have a number of positive effects, in particular:

- awards were considered critical for the recruitment and retention of consultants, notably for the best performers and for clinical academics;
- they provide a reward for consultants to work beyond their job description;
- they give recognition to consultants, thereby improving job satisfaction and motivation; and
- the schemes have contributed to the production of medical research.

4.4 In the same vein, the submissions put forward views on the potentially damaging impact of removing incentive awards, suggesting that this could:

- make recruitment and retention of the best staff more difficult;
- in particular, worsen the ability to recruit into academic posts; and make doctors less inclined to follow academic careers or become medical educationalists;
- narrow the contributions of consultants down to their contractual commitments;
- make consultants unwilling or unable to continue to do additional work to support the wider objectives of the NHS, the Health Departments and the United Kingdom governments;
- lead to consultants undertaking more private practice;
- push some individuals entirely into private practice or other industries;

¹ The full terms of reference for the review are given in Appendix A.

- deter doctors from entering specialties where there was limited scope for private practice;
- undermine a major incentive for doctors to engage in medical research;
- threaten the ability of postgraduate medical education to continue in its current structure;
- risk a long-term decline in quality of care and productivity in the NHS;
- lead to the early retirement of some consultants; and
- adversely affect gender pay equality in the profession.

4.5 There were some contributions that conflicted with this general consensus, with the suggestion that the number of awards was unwarranted on recruitment grounds, and that most recipients were aged over 50 and did not need a retention incentive. We go through the submissions in these areas in more detail below.

Recruitment and retention

- 4.6 We received a significant amount of comment on the positive effect of the awards on recruitment and retention. Indeed, many respondents stated that the award schemes were critical for recruitment and retention. The Association of United Kingdom University Hospitals said that recruitment and retention of the very best staff would be more difficult without the potential to gain additional performance-related remuneration. The Faculty of Occupational Medicine suggested that some consultants might retire earlier if the value of the higher awards was reduced.
- 4.7 There were few dissenting voices on the issues of recruitment and retention. One individual, however, believed that the sheer number of awards was not warranted on retention grounds. Another individual argued that awards above silver level served little purpose for retention as most of the recipients were aged over 50 and were less mobile in their careers.
- 4.8 Some comments were specifically related to consultants in Scotland. The Royal College of Surgeons of Edinburgh drew our attention to the potentially damaging impact of what it described as the “unilateral removal” of the merit system in Scotland and expressed concern that high achievers would be less likely to be recruited in Scotland if the potential for recompense was seen to be poor in comparison to the other devolved nations. It believed that this could be a particular issue for clinical academics who did not have the alternative income streams of private practice open to them. However, we note that neither the Management Steering Group of Scottish Employers nor the Scottish Government Health Department (SGHD) considered there to be any recruitment or retention problems among consultants in Scotland at present. Indeed, the forecast for Scotland is of an over-supply of qualified doctors between now and 2014.

Recruitment and retention of clinical academics

- 4.9 Many of those who addressed the importance of recruitment and retention did so in relation to clinical academics. We have devoted a separate chapter to clinical academics (Chapter 7), but for completeness we include here some of the comments received. The Royal College of General Practitioners told us that the schemes were an important factor in recruiting and retaining senior academic general practitioners, while the Committee of Postgraduate Dental Deans and Directors told us that recruitment and retention in academic dentistry was in crisis and that the award scheme was an incentive for those

who committed long term to an academic career. It believed that if the schemes were not retained, there was a real risk that the ability to recruit into academic posts would worsen.

4.10 In addition, many respondents expressed concern that a reduction in the opportunities to obtain Clinical Excellence Awards might make doctors less inclined to follow academic careers or become medical educationalists and leaders and that this could lead to a brain drain of clinical academics:

- the joint submission from the Academy of Medical Sciences, British Heart Foundation, Cancer Research UK and Wellcome Trust, warned that the removal of awards would undermine a major incentive for doctors to engage in medical research and could “stop the United Kingdom’s translational science agenda dead in its tracks”;
- the Conference of Postgraduate Medical Deans of the United Kingdom reported that deaneries were beginning to experience increasing difficulty in recruiting doctors to more senior educational leadership roles such as heads of postgraduate schools and training programme directors. It said that it firmly believed that the loss of the Clinical Excellence Award system would only make the situation worse, threatening the ability of postgraduate medical education to continue in anything like its current structure;
- the Society for Academic Primary Care observed that without access to Clinical Excellence Awards, the vast majority of full-time senior academic general practitioners would earn substantially less than the average full-time general practitioner partner. Therefore, a scaling back or withdrawal of the awards scheme would seriously affect the retention of the most talented and experienced senior academic general practitioners;
- the Medical Research Council expressed a particular concern that contracted clinical academics in its units might relocate rapidly into the universities and cause disruption to long-term research programmes; and
- the Universities and Colleges Employers Association stated that, without the help of Clinical Excellence Awards, universities would be forced to consider the use of market supplements and alternatives, which would “create a considerable drain on resources at a time when higher education was facing cuts on an unprecedented scale”. It went on to say that there were powerful disincentives to embarking upon a clinical academic career and Clinical Excellence Awards had been a useful counter-balance to these disincentives in providing some compensation for eschewing the greater pecuniary rewards that would have been available to many clinical academics had they entered other branches of the profession. It said that the national Clinical Excellence Award scheme was critical to the recruitment and retention of senior clinical academic and other senior clinical staff in the United Kingdom’s clinical academic centres.

4.11 Many respondents believed that if the national scheme was scaled back, then some consultants would carry out more private practice, particularly in the better-paid specialties, or seek other sources of income outside the NHS, including moving overseas. The Renal Association said that some individuals would move into private practice, the pharmaceutical industry, or to posts outside medicine that were better rewarded. We were also told that a significant reduction in the remuneration from Clinical Excellence Awards would deter doctors from entering specialties where there was little or no scope for private practice. For example, the British Association for Sexual Health and HIV pointed out that specialties dealing with socially deprived groups had less opportunity for private practice.

Motivation and morale

- 4.12 One of the main purposes of any contingent pay scheme is to motivate individuals to achieve higher levels of performance and to increase their competencies and skills.² It may be the case that the recognition from incentive schemes, such as those available to consultants, is more motivating than the cash value of awards.³ This may particularly be the case where the reward is not closely linked to defined targets or standards.⁴ It has also been recognised that the withdrawal of awards can demotivate more than the original award motivated. It has been suggested that incentive schemes may fail if the job attracts those who are intrinsically motivated, such as the “helping professions”.⁵ It may be the case that using pay as an incentive undermines individual and organisational performance because it hinders teamwork, encourages a short-term focus, and “leads people to believe that pay is not related to performance at all but to having the ‘right’ relationships and an ingratiating personality”.⁶
- 4.13 A study on performance pay in the public sector⁷ concluded that public sector workers do respond to payment-for-performance schemes, but that the evidence for this occurring in the healthcare field was relatively weak compared to that for civil servants and teachers. The research also found evidence of gaming, whereby behaviour was manipulated in response to incentive schemes, but did not result in an increase in productivity. The report did conclude, however, that, in the public sector, financial incentives gave a clear message about which outcomes were valued by society, and by how much, so that employees could prioritise their time and effort towards the higher-valued work. The research found that quality improvement was the main focus of the payment-for-performance schemes in the healthcare sector and that incentives were more effective where the potential reward was larger and the payment frequency higher. Unfortunately, while the researchers looked at the healthcare sector, this was mostly in relation to general medical practitioners and there is no mention of Clinical Excellence Award schemes or their like.
- 4.14 We had a number of responses that addressed the motivational impact of consultants’ awards. The majority of those who responded on this issue were keen to stress the importance of the scheme in providing satisfaction that the consultants’ work is recognised by peers. The Royal College of Physicians told us that while one effect of the award was financial, it was also a source of pride to recipients, and the factors of lay, employer and peer assessment involved were significant and unique. The Scottish Advisory Committee on Distinction Awards (SACDA) said that the professional status and recognition that was gained on receipt of an award had a strong motivational influence on the work undertaken for the NHS in Scotland by consultants.

² Michael Armstrong and Helen Murlis. *Reward management: a handbook of remuneration strategy and practice*. Revised 5th ed. Kogan Page, 2007: 300.

³ Herzberg’s Hygiene theory. In: Sarah Hollyforde and Steve Whiddett. *The motivation handbook*. Chartered Institute of Personnel and Development, 2002: chapter 23.

⁴ Michael Armstrong and Helen Murlis. *Reward management: a handbook of remuneration strategy and practice*. Revised 5th ed. Kogan Page, 2007: 308

⁵ Myron Glassman *et al.* Evaluating pay-for-performance systems: critical issues for implementation. *Compensation and Benefits Review*. 42(4) July-August 2010: 231-238.

⁶ Jeffrey Pfeffer. Six dangerous myths about pay. *Harvard Business Review*. May-June 1998: 109-119.

⁷ Graham Prentice *et al.* *Performance pay in the public sector: a review of the issues and evidence*. Office of Manpower Economics, November 2007. Available from: http://www.ome.uk.com/Cross_cutting_Research.aspx

- 4.15 Some respondents pointed out that while receipt of the awards was motivating, not getting them was demotivating. The Faculty of Occupational Medicine warned that the adverse impact of taking away an attained or expected benefit was likely to be greater than the positive impact of making the same benefit available to someone who was not expecting it. One individual, the holder of a national B award, commented that many consultants who believed they were achieving clinical excellence, and whose colleagues and patients thought likewise, never achieved a national award or never progressed within the system, and became disillusioned and stopped trying. He believed that the disincentive of failure to achieve, to be considered not excellent enough, was real and should not be underestimated.
- 4.16 We were told by the Society for Cardiothoracic Surgery in Great Britain and Ireland that consultants' motivation to drive improvement across the NHS was enhanced by the possibility of acknowledgement through the award schemes, particularly as Supporting Professional Activities came under pressure in job plans. The British Paediatric Neurology Association said that the award system motivated non-recipients and trainees to work together better and more enthusiastically.
- 4.17 One consultant warned that there would be an adverse impact on morale if the value of the current awards was reduced. However, another believed that the current scheme was no longer fit for purpose in motivating individuals.

The extra-contractual contributions of consultants

- 4.18 Some respondents commented that if the award schemes were reduced, the loss of work "above and beyond" that expected of a consultant would be permanent and that consultants would deliver no more than the care paid for by their contracted Programmed Activities. The British Medical Association pointed out that Supporting Professional Activity time was already being reduced. It said that if awards were also reduced, it would be hard to see how consultants would be willing or able to continue doing some of the additional work undertaken to support the wider objectives of the NHS, the Health Departments and the United Kingdom governments. Furthermore, the British Society of Periodontology argued that curtailing the system would result in the loss of a substantial amount of goodwill from committed consultants who delivered "over and above" their job descriptions. The Renal Association suggested that if the incentive created by the rewards was to be removed the majority of consultants would stop, or greatly reduce their contributions outside a narrow interpretation of their contractual commitment. The British Pain Society warned that while short-term financial gains might be made, there was the risk of a long-term decline in quality of care and productivity in the NHS.
- 4.19 The Medical Research Council said that over half of the consultants who contributed to its review highlighted the positive effect that Clinical Excellence Awards had in terms of providing an incentive to work over and above their role requirements. It quoted one as saying: "they are a long-term incentive to outperform the job description significantly, to innovate, to develop new services".
- 4.20 *We recognise that the awards are perceived by the medical profession as having a strong influence on recruitment and retention, and provide both an incentive to work beyond the job role and recognition for doing so. Awards may be particularly influential in the recruitment and retention of clinical academics.*

Impact on clinical outcomes

- 4.21 The evidence on the impact of award schemes on clinical outcomes is limited. One recent study⁸ found a correlation between the receipt of local and national awards with years of experience and the rate of academic citation (a measure of research productivity) amongst psychiatrists, with the citation rate being particularly important for national awards.
- 4.22 An earlier study found that consultant surgeons who held local awards undertook significantly more activity than those without an award, measured in terms of finished consultant episodes. Those with national awards had a tendency towards higher activity rates, but this was not statistically significant.⁹ The same researchers found a relationship between those holding local awards and hospital consultant activity rates, again measured by finished consultant episodes, but no statistically significant difference in consultant activity between those with a national award and those without.¹⁰
- 4.23 *The correlation between activity rates and local, but not national, awards is understandable if local awards are awarded for a greater local clinical contribution, whereas national awards are for contribution to the wider NHS, not for direct services to patients. However, all of these studies establish a correlation, not causation: it is likely that awards recognise a greater contribution rather than stimulate it.*
- 4.24 The Academy of Medical Sciences, British Heart Foundation, Cancer Research UK and Wellcome Trust (in their joint submission) considered it almost certain that the Clinical Excellence Award system has contributed causally to the excellent productivity of biomedical research in the United Kingdom. The British Medical Association told us in oral evidence that the narrowness of consultant income made it difficult to prove a causal effect between awards and excellence.
- 4.25 Bloor and Maynard agreed with the difficulty in establishing a causal link between the awards and outcomes, in supplementary evidence to this review, and said that they did not claim any causation in their earlier modelling, their analysis simply reflected that Discretionary Points/Clinical Excellence Awards appeared to be awarded to more productive consultants. This was an association rather than any clear causation, and suggested that the schemes rewarded high performance, but did not necessarily cause it. They went on to say that their analyses were based on a 'quantity effect' and made no comment on quality or overall performance. They could not tell from the data whether consultants neglected other work. They were not convinced that this was compelling evidence for even a local award scheme stimulating productivity or performance, although it provided some evidence that the award scheme was distributing local level awards to 'productive' consultants.

⁸ Alex Mitchell *et al.* Does the academic performance of psychiatrists influence success in the NHS Clinical Excellence Award Scheme? *Journal of the Royal Society of Medicine Short Reports* 2(3) March 2011: 2-9.

⁹ Karen Bloor, Nick Freemantle and Alan Maynard. Variation in the activity rates of consultant surgeons and the influence of reward structures in the English NHS. *Journal of Health Services Research and Policy* 9(2) April 2004: 76-84.

¹⁰ Karen Bloor, Nick Freemantle and Alan Maynard. Gender and variation in activity rates of hospital consultants. *Journal of the Royal Society of Medicine* 101(1) 2008: 27-33.

International medical job market

4.26 Our secretariat commissioned Capita Surveys and Research to undertake research into how consultants, or equivalent senior medical and dental staff, are compensated or remunerated in a number of countries including those which attract United Kingdom consultants.¹¹ The research brief was to provide an overview of current remuneration methods for medical and dental consultants (including clinical academics), or doctors and dentists with similar seniority and skills, in other countries,¹² with a specific focus on incentive, performance or bonus schemes. The main findings of Capita's research are outlined below, and in Table 4.1.

- The model of pay determination for senior medical staff varied in each country but there were broad categories that could be identified. The Republic of Ireland, New Zealand, and Australia had a national or state level framework, matching government involvement in healthcare policy and funding, where collective negotiation and/or periodic independent review set the main pay rates and terms and conditions. In contrast, the United States of America and Canada had a higher level of individualised or local pay determination, with remuneration generally on a fee-for-service basis.
- While there were a variety of arrangements for making additional payments to senior doctors, based on merit, performance, seniority and choice of speciality and geographic location, Capita did not find any schemes similar to the Clinical Excellence and Distinction Award schemes in the United Kingdom.
- Earnings variations between specialities appeared to be most pronounced in the United States of America – incomes in some surgical specialties were reported to be up to three times greater than those in family medicine.
- Additional payments for out-of-hours work, management responsibilities, recruitment and retention supplements were also reported in most countries, usually with a well-structured and transparent schedule of payments.
- The countries with a national or regional pay determination framework also reported transparent mechanisms for enabling senior medical and dental staff to undertake agreed levels of private practice.

4.27 We also received some submissions on the international job market, mainly relating to the effect of the perceived higher levels of remuneration overseas. The British Medical Association told us that award schemes helped to retain and recruit excellent staff in what was in many areas an international market, and the Association of United Kingdom University Hospitals told us that salary levels for clinical leaders in other G20 countries were far above the top of the consultant scale.

¹¹ *Compensation levels and incentive systems for medical and dental consultants: international experience*. Capita, March 2011. Available from: http://www.ome.uk.com/DDRB_Research.aspx

¹² The countries of interest were specified as Australia, New Zealand, the Republic of Ireland, Canada, United States of America, and other European countries including Germany, France, Switzerland, Italy, Spain, Netherlands, Belgium, Sweden, Norway, and Denmark.

- 4.28 The Advisory Committee on Clinical Excellence Awards (ACCEA) observed that the main comparative issue for clinical academics seemed to be with overseas competitors, as the remuneration levels were believed to be significantly higher in other countries. It said that the availability of Clinical Excellence Awards bridged the gap to some extent, although some academic institutions had paid remuneration levels equivalent to national Clinical Excellence Awards in order to recruit doctors and had underwritten the amount pending successful applications for awards. ACCEA also believed that similar practices were occurring for the international inward recruitment of doctors to service roles, although it had no evidence to support this. However, to date, it had resisted pressure to allow doctors to enter the national scheme at levels higher than bronze. The British Society of Periodontology commented that without such award schemes, recruitment of the brightest and most committed young clinical academics to drive research, innovation and education in the future would suffer, and that there was a real risk of a further brain drain to the private sector or abroad.
- 4.29 The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) considered it unlikely that doctors in the international medical market would be significantly influenced by the Clinical Excellence Award scheme. It pointed out that it took some time to become eligible for a higher award and that financial constraints limited the number of higher awards. The Department also pointed out that consultant remuneration was far higher in the Republic of Ireland, but there was little or no evidence of loss of medical staff to the Republic. However, the British Society for Rheumatology observed that the highest achieving doctors had the greatest opportunity to move abroad, and said that this was particularly true for leading clinical academics or internationally recognised clinical experts. It said that the awards scheme had ensured that many leading experts remained in, or were attracted to, the United Kingdom, even though greater financial rewards might be available elsewhere.
- 4.30 The Conference of Postgraduate Medical Deans of the United Kingdom noted in supplementary evidence that the most significant problems with medical supply were to be found in English-speaking countries in North America and Australasia. Those countries were engaged in recruitment campaigns at all levels: from the very top of the profession involved in high-level management and administration of services, the development of innovative care systems or care management approaches, research and education and training, to those who were simply providing day-to-day services within healthcare systems/sectors or individual organisations.
- 4.31 In summary, our international research has not identified any directly comparable award schemes. Within the United Kingdom, however, the Ministry of Defence has its own Clinical Excellence Award scheme for consultants, based on the NHS scheme.

Table 4.1: Remuneration of consultant-equivalent doctors and dentists in English-speaking countries

	United Kingdom	Australia	New Zealand	Republic of Ireland	Canada	United States of America
Type of health system	Public with some private provision	Public with some private insurance	Public with private hospitals; some private insurance	Public and private/voluntary hospitals with public/private insurance	Public with some private provision	Private but with public subsidy through Medicare/Medicaid
Employment status of consultants	Employed with some private practice rights	Employed with some private practice rights	Employed with some private practice rights	Employed with some private practice rights	Self-employed and employed	Self-employed and employed
Method of pay determination	National pay scales	State certified agreements	National agreement	National agreement	Fees determined on a state basis	Fees determined by Medicare and insurers
Basic pay range (£)	74,504 – 100,446	86,002 – 116,254	60,471 – 91,913	156,577 – 163,448		
Average total earnings (£)	119,800 ¹³		106,192		203,712	Wide variation depending on speciality
Other benefits		Salary packaging for reducing taxation liability	Additional benefits for recruitment and retention purposes	Special contribution benefit for recruitment and retention		
National Scheme to reward excellence or performance	Yes – Clinical Excellence Awards/ Distinction Awards	No	No	No	No	No
International medical graduates		Significant proportion of doctors in rural areas are international medical graduates	Inward from United Kingdom, South Africa; outward primarily to Australia. 40% of consultants are international medical graduates		Significant proportion of doctors in rural areas are international medical graduates	Significant proportion of doctors in rural areas are international medical graduates

Note: Currencies have been converted into pounds sterling using the monthly average exchange rate as at 28 February 2011 as published by the Bank of England.

Source: Capita.

¹³ NHS Information Centre Staff Earnings Estimates, October – December 2010. Data relate to NHS income only.

Total reward for consultants¹⁴

- 4.32 Total pay for consultants is comprised of basic pay; additional Programmed Activities/ Supporting Professional Activities; on-call supplements; Clinical Excellence Award/ Distinction Award/Discretionary Point payments; and other fees and allowances. The current levels of payments are at Appendix D. Consultants can also substantially increase their earnings through private practice.
- 4.33 The total reward package for consultants is extensive. Consultants receive the additional benefits that are available to all NHS employees, including a defined benefit pension scheme, up to 32 days' annual leave, plus ten statutory days, professional and study leave, career breaks, maternity leave of up to one year, paid sick leave, and opportunities for flexible working. The consultant role also offers valuable opportunities for personal development through carrying out research and teaching, significant non-financial recognition and status, and relatively high job security.
- 4.34 Some of the submissions commented on total reward for consultants. The Guy's and St Thomas' NHS Foundation Trust believed that Clinical Excellence Awards should not be uncoupled from the basic salary of consultant medical staff; instead the total remuneration package for doctors throughout their careers should be considered.
- 4.35 NHS Employers pointed out that awards should not be seen in isolation to the main terms and conditions and pay rates, additional Programmed Activities, responsibility payments, waiting list initiative payments, study leave, employer pension contributions and other non-pay rewards. Overall, the investment in consultant pay over recent years had seen a large increase in the medical pay bill and in the average earnings of consultants.
- 4.36 The Department of Health estimated the value of the total employment package to consultants (including employers' pension contributions, annual leave over the statutory minimum, sick leave and study leave) to add around 20 per cent to the value of the basic reward package.¹⁵

Pay comparability

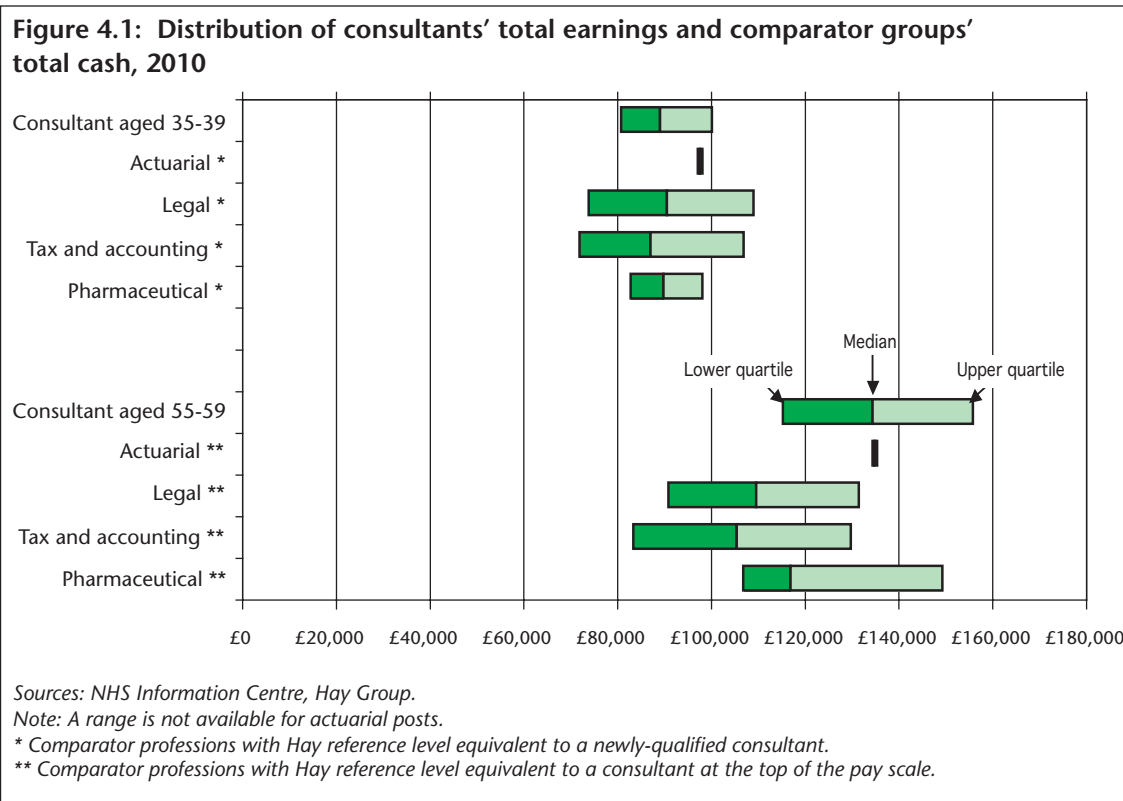
- 4.37 In evidence, the Department of Health said that findings from the 2009 staff survey indicated that current pay levels were sufficient to recruit, retain and motivate a strong consultant workforce. There was no evidence to suggest that overall pay levels were too low.
- 4.38 *Each year our secretariat provides us with an assessment of the pay position of our remit groups relative to other groups that could be considered comparator professions. The specific comparator professions that we use are: legal, tax and accounting, actuarial and pharmaceutical.¹⁶ The most recent data indicated that median basic salaries and total earnings for newly-qualified consultants were lower than those in the private sector occupations included in the comparison (Figure 4.1). For an experienced consultant, however, median total earnings were higher than median incomes for most comparator occupations. Taking all the evidence together, we are content with the overall level of compensation for consultants. However, this review has identified a number of aspects with the current total*

¹⁴Total reward – incorporates the total remuneration package (total cash plus total direct compensation) plus engagement factors (for example, quality of life, work-life balance, inspiration and values, enabling environment, growth and opportunity) which contribute to internal value or motivation.

¹⁵The basic reward package included basic pay, Clinical Excellence Awards, out-of-hours/on-call allowances and an average of one additional session.

¹⁶The pay comparators were identified in the report: PA Consulting Group. *Review of pay comparability methodology for DDRB salaried remit groups*. Office of Manpower Economics, 2008. Available from: http://www.ome.uk.com/DDRBR_Research.aspx

reward package for consultants with which we have some concerns. Our observations and recommendations in this report are intended to address those concerns.



The basic pay structure

4.39 Guy's and St Thomas' NHS Foundation Trust told us that the NHS needed a better system of career progression for consultants, with a reward strategy that was more transparent and could be flexed up or down during a career. On a similar theme, one individual response suggested an extended career structure for doctors, with earned increments and a senior consultant grade, where doctors would gain extra status and income through a clear promotion procedure, without leaving their clinical environment.

Observations on the basic pay scale

4.40 We make the following observations on the basic pay scale. The current basic pay scale for consultants in England, Scotland and Northern Ireland has eight pay points (see Table 5.5). Points 2 to 5 are awarded annually for the first four years in post, points 6 to 8 are awarded after each subsequent five years of service, so it takes a consultant 19 years to reach the pay band maximum. Pay progression is dependent on an individual fulfilling their job plan and participating in the appraisal process; although we understand that in practice few increments are withheld. While we recognise that performance should increase with the years in a job, we believe that the extent to which experience alone is rewarded should be more limited than the current pay scale permits. It is our view that the current system pays increments for a consultant continuing to carry out their basic job, rather than reflecting the evidence of job growth that a progression system should reward. We believe that the current structure rewards length of service more than contribution or performance, and provides less of an incentive for job growth or development than we would expect, with, in practice, only a weak link to appraised performance. Near-automatic progression is not typically a feature of any of the professional roles we use for comparators at this level.

- 4.41 *The consultant pay scale in Wales, with Commitment Awards made on a time-served basis, on top of the basic pay scale, exacerbates this issue. We are unable to support a pay system that rewards length of service, in this case for up to 30 years, rather than the achievement of excellence.*
- 4.42 *We urge the parties to review the basic pay scale, with a renewed emphasis on rewarding performance and encouraging career development. We would like to see the pay scale limit progression for all effective/satisfactory performers to the first five pay points, with no fixed pay points beyond this salary (currently £83,829), apart from the maximum. We expect all consultants to be clinically capable in their role: sub-standard performance should be addressed robustly outside the reward system. Further progression towards the maximum would be a matter for the local employer to determine, on the basis of individual performance. We recognise that implementation of such a system would require an effective performance management system. We also recognise that this will mean that some consultants may not reach the maximum of the pay scale.*

Observation 1: The parties should review the basic pay scale, with a view to moving the emphasis towards rewarding performance and encouraging career development, and away from paying for length of service.

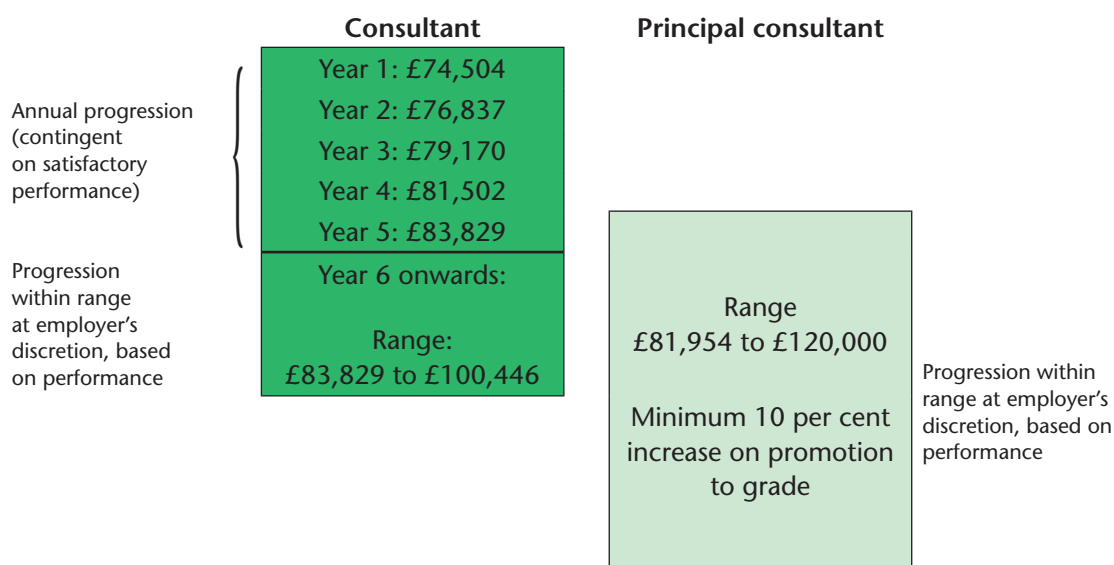
Principal consultant grade

- 4.43 *Allied to our comments on the basic pay scale, we observe that a single consultant grade, often attained relatively early in an individual's career, limits the opportunities for career development and job growth. We would like the parties to explore introducing a principal consultant grade, to which experienced, high-performing consultants, who are undertaking a larger role in terms of service delivery, expertise or leadership can be promoted. Over time, we would expect only a small proportion of consultants, say up to 10 per cent, to reach this level, following a rigorous process for appointment, and such a grade should not just reward time served. We would expect the number of available posts to be determined locally to meet the needs of each employing organisation, with the option to move consultants in and out of the grade. The initial salary for this grade would take the form of a 10 per cent pay increase on promotion, from any point in the main consultant pay range. The maximum salary for the grade would be £120,000, with any progression within the range based on performance and contribution, at the employer's discretion. The salary for the principal consultant would be consolidated and pensionable. If principal consultants are moved back into the main consultant grade, we do not believe that any pay protection provisions should apply. Principal consultants would also be eligible for the new award schemes outlined in Chapters 5 and 6, but this new grade would not be open to those still in receipt of an award under the old schemes: we see this new grade as part of an integrated package with the new award schemes. We envisage that certain posts within an organisation may be designated as principal consultant positions and filled from external or internal recruitment, while, in other cases, individuals undertaking highly specialist and demanding roles may be promoted to this grade.*

Observation 2: The parties should consider introducing a principal consultant grade.

- 4.44 *Our observations on pay scales are part of an integrated package for consultants which should be implemented alongside our recommendations for the new award schemes. Figure 4.2 summarises our suggested model for a future basic pay and career structure for consultants.*

Figure 4.2: Model for a future basic pay and career structure for consultants based on salary scales as at April 2011



Other additions to basic pay

- 4.45 While a standard full-time consultant post consists of ten Programmed Activities, consultants are often contracted to work additional Programmed Activities on top of this standard commitment. We received no evidence on this aspect of additional remuneration, so conclude that it is not a substantial issue. We would observe, however, that this kind of contractual overtime is not an element of pay that would be seen in comparable professions. We agree that employing organisations should continue to use additional Programmed Activities as a flexible resource to meet work demands, and note the successful part that this practice has played in the past in reducing waiting lists.
- 4.46 There was a similar absence of evidence on the other additions to basic pay, notably on-call supplements and recruitment and retention premia. We have commented upon the infrequent use of recruitment and retention premia for consultants in the past.¹⁷

The need for compensation levels above basic pay scales

- 4.47 We received submissions from a number of respondents on the need for compensation levels above basic pay scales. For example, the British Medical Association commented that at an average of 8 per cent, Clinical Excellence Award income as a percentage of salary was substantially below that received by senior managers in both the private and public/not-for-profit sectors in the form of bonus payments. Quoting from Incomes Data Services,¹⁸ it said that bonuses for function heads in the public/not-for-profit sector averaged 11.3 per cent of base salary and in the private sector, 24 per cent.¹⁹
- 4.48 Several respondents pointed out that once consultants were appointed to the grade, there was no prospect of promotion, and salary advancements could be achieved only through incremental progression, until the maximum salary point was reached. ACCEA pointed out that consultants reached this position at a relatively early stage in their

¹⁷ Review Body on Doctors' and Dentists' Remuneration. *Thirty-ninth report*. TSO, 2010: para. 7.14. Available from: http://www.ome.uk.com/DDRB_Main_Reports.aspx

¹⁸ *The managers' benchmark pay report 2009/10*. IDS Executive Compensation Review. Research file 81. Incomes Data Services, December 2009.

¹⁹ In our view, this is not a valid comparison. In Chapter 3, we conclude that consultants' awards are a form of contribution-related pay rather than bonuses.

careers and that without the opportunity to gain Clinical Excellence Awards they would find themselves at mid-career with no prospect of significantly increasing their earnings.

- 4.49 The Northern Ireland Clinical Excellence Awards Committee (NICEAC) questioned whether those who made important contributions to medicine and healthcare, over and above contracted duties, should be paid the same as those who undertook the minimum work required by their contract. It noted that some of those who did the minimum required, may put the greatest part of their efforts into other activities, including private practice. The British Society for Rheumatology said that if the need for an incentive scheme was accepted, then using compensation levels above the standard pay scale was an entirely appropriate way to do it. It noted that the concept of using pay to differentiate among employees was commonplace in the public and private sectors. The Royal College of Surgeons of Edinburgh commented on the need to recognise and reward dedication and commitment in the broader sense.
- 4.50 One individual response proposed the use of compensation levels above basic scales for specialties or geographical areas where there were recruitment difficulties. A few individuals suggested that the award schemes should be abolished and consultants paid more. One individual proposed distributing equally, amongst all the consultants in the NHS, the money spent on the current awards.

The need for incentives

- 4.51 Almost all respondents to the consultation supported the continuation of an incentive scheme. For example, ACCEA told us that the Clinical Excellence Awards scheme provided an incentive to excellence for eligible doctors and dentists and that those who received awards received confirmation that their contribution was appreciated in addition to remuneration for sustained excellence. It believed that without the scheme, consultants' remuneration would not fairly reflect their contribution to the NHS. The British Dental Association expressed concern that the value of the scheme in promoting exceptional performance within the NHS and world-class research within academia could be undermined if the primary aim of the review was to reduce the cost of the scheme. It argued that the value of the scheme to the NHS and academia was evident in the outcomes it had supported, not the material benefits it appeared to offer individuals in receipt of rewards. The British Medical Association told us that the importance of valuing and rewarding innovation, service improvement, research, training and leadership was even more important now than it had been at the start of the scheme in 1948.
- 4.52 The Department of Health stated that it wished to continue to reward and recognise consultants who provided outstanding patient care and made major achievements in their NHS work. It therefore accepted the need for some compensation levels and incentives above basic pay scales for NHS consultants. It said that the aim should be to reward consultants at levels that would incentivise excellence, within available NHS resources. The DHSSPSNI said that it was right that consultants who demonstrated excellence in delivering, developing or managing a high quality professional service, either locally, nationally or internationally, or who made major contributions to teaching, training or research, should have the incentive of an award system. NICEAC told us that while it believed that some form of reward system should exist, the review provided an ideal opportunity to assess the most appropriate way of incentivising excellence, whether through monetary or other methods of recognition. SACDA had made its response on the assumption that there would continue to be some kind of award scheme, but noted that the Scottish Government had the option of winding up the scheme. The Wales Awards Committee of ACCEA said that it favoured strongly the retention of an awards scheme for consultants in NHS Wales and the Welsh Assembly Government told us that it would wish to continue to reward and recognise consultants who provided outstanding patient care and made major achievements in their NHS work.

- 4.53 With regard to the need for incentives, the DHSSPSNI observed that the consultant contract rewarded individuals for the quantity of work undertaken rather than the quality. It believed that some form of award system should be in place to reward those consultants who delivered a service over and above that required in their job plan. However, the Department stressed that there should be no awards granted for work already remunerated through payment for additional Programmed Activities. NICEAC believed that incentives were required: to encourage long-term excellence; for recognition; for comparability as other professional groups rewarded exceptional work; for staff retention; to reward contributions to the wider NHS; and to recognise quality of work. The SGHD noted that, for many individuals, elements such as status, quality of work and peer recognition might play as important a role as financial reward.
- 4.54 The Academy of Medical Royal Colleges said that national Clinical Excellence Awards provided an important incentive for doctors to become involved and remain involved in work for the wider NHS. The British Society for Rheumatology stated its belief that incentives increased motivation and that the high international reputation of medicine in the United Kingdom depended on senior doctors maintaining an ongoing contribution to clinical practice and further contributing to the NHS in management, teaching, working with deaneries, specialist societies and colleges, working with patient groups, and undertaking and supervising national and international level research. The Royal College of Radiologists told us that the system was needed to maintain the higher functions of the NHS. It was a driver for carrying out additional work in the evenings and at weekends. Without it, the College believed that doctors might carry out additional responsibilities only if they received extra funded sessions.
- 4.55 Of those, who were less positive about the scheme, NHS Employers reported that employers were divided on whether the scheme should continue. Many employers wanted the scheme to end, while others could see benefit in rewarding outstanding contributions made by medical staff. However, they reported broad agreement among employers that the current financial and policy architecture was not fit for purpose. They said that the majority of employers would want an end to the scheme if their concerns about the arrangements were not addressed. NHS Employers were critical of a number of aspects of the scheme, including the requirement to spend an allocated proportion of the pay bill regardless of the number and quality of applicants, of the value of awards and their portability to new employers. The SGHD said that the scheme needed to be reformed to achieve a fairer and more cost-effective method of rewarding excellence across the NHS. The Management Steering Group of Scottish Employers told us that there were arguments that the schemes should be abolished. They suggested that there was a need to consider whether the budget for awards represented a good use of scarce resources. One individual believed that there was an excessive number of awards in Scotland; another suggested removing the scheme altogether and replacing it with a simpler and clearer reward structure.
- 4.56 *Our terms of reference require us to consider the need for compensation above the basic pay scales, and the need for incentives to encourage excellence. Incentives are used to encourage people to achieve their objectives, improve their performance or enhance their competence or skills by focusing on specific targets and priorities. Rewards provide financial recognition to people for their achievements in attaining or exceeding their performance targets or reaching certain levels of competence or skill.²⁰*
- 4.57 *The consultant body is large and heterogeneous, and the reward structure needs to recognise differences in the scope of jobs undertaken, the excellence with which the roles are performed, and the many opportunities for consultants to work beyond their basic jobs. A new principal consultant grade would recognise sustained, outstanding performance in roles that carry more*

²⁰Michael Armstrong. *Employee reward*. 3rd ed. Chartered Institute of Personnel and Development, 2002: 252.

responsibility, leadership, specialism, or that make particular demands on the job holder; while a revised consultant grade would enable excellent performers to be rewarded and encourage career development. We believe that variable award schemes are also required, however, to reward, recognise and provide incentives for those consultants who go significantly beyond their basic job, both in terms of providing a service to patients, and in contributing to the development of the NHS as a whole, through research, teaching, professional development or developing innovative practice. It is appropriate for this element of pay to be non-consolidated: first, because such a contribution is variable and discretionary; second, because it is likely to change over time; and third, because it incentivises continued high levels of performance. Non-consolidated awards enable the available pot of money to be targeted at current excellence, rather than being a retrospective payment that continues to reward contributions made in the past.

Recommendation 1: We recommend that consultants continue to receive reward above their basic pay scales, where appropriate, and are eligible for incentives to reward excellence.

Non-pay incentives

- 4.58 It has been argued that pay that is supplemented by non-financial motivators can have a more powerful and longer-lasting effect; the financial and non-financial part of the reward package can augment each other.²¹ The total reward package for consultants includes intrinsic elements, without specific monetary value, which contribute to motivation. Individual engagement may be enhanced through quality of work, work-life balance, inspiration or values, an enabling environment and future growth opportunity.²² Recognition can be a strong motivator and many respondents to the consultation commented on the value of peer recognition arising from the award schemes. Reputation, which is enhanced by holding an award, is also of importance to consultants, although this could also apply to the reputation of the employing organisation.
- 4.59 The Department of Health submitted an additional paper to us on non-financial incentives. It referred to a report it had commissioned from RAND Europe²³ which looked at non-standard ways to support and reward excellence in health research. This report concluded that there was merit in developing incentives to support excellence in addition to standard performance measurement. Non-standard incentives could act to either reinforce the signals created by standard metrics, for example, awards recognising the best performers, or they could “fill the gaps” to encourage behaviour not influenced by conventional incentives.
- 4.60 In response, the British Medical Association said that consultants were pleased to receive non-financial rewards at the present time, where such awards existed. It noted that non-financial rewards were received with alacrity partly because they also contributed to the development of an effective application within the Clinical Excellence Awards process. It said that it was not valid to imply that the non-financial reward alone would be perceived as having the same value in the absence of a Clinical Excellence Award system. It did not object to the use of non-standard incentives for consultants as long as these did not replace the long-standing system of financial incentives for consultants. It went on to say that, if non-standard incentives were to be used to replace the existing system of financial clinical awards, it was extremely unlikely that this would achieve the same impact on

²¹ Michael Armstrong. *Employee reward*. 3rd ed. Chartered Institute of Personnel and Development, 2002: 363.

²² Michael Armstrong and Helen Murlis. *Reward management: a handbook of remuneration strategy and practice*. Revised 5th ed. Kogan Page, 2007: 15.

²³ Tom Ling. *A prize worth paying? Non-standard ways to support and reward excellence in health research and development in the UK NHS*. RAND Europe, 2011. Available at: www.rand.org/pubs/occasional_papers.html

consultant motivation and drive for clinical excellence as the current clinical award schemes.

- 4.61 *In our view, non-pay incentives could form an important part of the total reward package for consultants. They can contribute to motivation in a cost-effective way. Any non-pay incentive schemes should be designed to take account of both the intrinsic motivation of consultants and the nature of the health service in which they work.²⁴ Consultants are typically highly-motivated individuals, committed to the provision of an excellent public health service. However, care needs to be taken in designing schemes to ensure that they support the existing commitment of consultants without devaluing it.²⁵*

Other members of the clinical team

- 4.62 The issue of team pay was not a common theme in the evidence submitted to us. NHS Employers did report, however, that a concern of some employers was that the current arrangements covered only consultant doctors, thereby overlooking nurses, allied health professionals and others who contributed to extended service roles and innovative practices and suggested that local schemes might want to reflect this in any criteria and payments. A number of other respondents questioned whether it was fair and equitable that the scheme should be confined to consultants.
- 4.63 The Management Steering Group of Scottish Employers and NHS Employers were critical of the disconnection from the reward and encouragement of excellence elsewhere in the workforce. We received suggestions from the Royal College of Anaesthetists and SACDA that specialty doctors should be included in an award scheme. The British Society for Gynaecological Endoscopy wanted the schemes extended to nurse consultants, the British Thoracic Society to nurse practitioners, and the Royal College of General Practitioners argued for the inclusion of non-academic general practitioners with leadership roles. One individual told us that in Scotland, Distinction Awards had the capacity to cause resentment among other healthcare workers (as well as non-recipient consultants) who sustained high standards. The SGHD suggested that we should commission advice from the NHS Pay Review Body about a scheme for rewarding excellence across the clinical team. However, the British Medical Association pointed out that any extension of the scheme would require a commensurate rise in funding and the Conference of Postgraduate Medical Deans of the United Kingdom said that if other professional groups needed to be rewarded, then this should be funded by top-slicing their own salary pot.
- 4.64 The Scottish Government reported a growing perception that merit schemes unfairly rewarded already highly-paid consultants when other clinical staff had no access to such schemes. It suggested that the perpetuation of a scheme restricted to a particular class of employees might well be open to challenge under employment and anti-discrimination legislation. It said that there was a need to consider whether any scheme should be confined to only one group of the NHS workforce, although its own proposals for a revised excellence awards scheme, suspended pending the outcome of this review, remained limited to consultants.

²⁴Timothy Besley and Maitreesh Ghatak. Competition and incentives with motivated agents. *American Economic Review* 95(3) 2005: 616-636.

²⁵Bruno Frey and Felix Oberholzer-Gee. The cost of price incentives: an empirical analysis of motivation crowding-out. *American Economic Review* 87(4) 1997: 746-755.

- 4.65 Several respondents alluded to the now extinct Discretionary Points system for nurses. This was in place from 1998, as an interim measure, and was superseded by *Agenda for Change* in 2004. We understand that, at the time, the scheme and its operation were widely criticised by both employers and the Staff Side unions.
- 4.66 Separately from the evidence submitted to this review, Bloor and Maynard have made a case for team rewards within healthcare.²⁶ They argued that team, rather than individual, performance-related pay was more practicable in healthcare, as health professionals might be better able to monitor each other's productivity than a non-clinical manager. They said that instead of giving individual consultants Distinction Awards for successes that were partly due to their team, the rewards could go to the whole team. Team members would have incentives to monitor each other's performance. They believed that this would address the usual asymmetry of information between doctors and their patients and employers that hampered the monitoring of performance.
- 4.67 *It is outside the remit for this review to make recommendations with regard to any other group than consultants; we are therefore only able to make observations on whether other staff groups should have access to award schemes. We see no reason why, in principle, other members of the clinical team should not be eligible for local and national awards. However, we think that the question of whether or not it is necessary for other groups to have access to award schemes is properly one for the relevant parties for such groups to consider. In our view, access to award schemes would need to be justified by robust market data in line with the overall reward strategy. Were such a scheme to be implemented, we believe it would require separate, additional funding.*

Reviews of senior pay in the public sector

- 4.68 We are required under our terms of reference to take account of the work on public sector senior remuneration carried out by the Review Body on Senior Salaries (SSRB). The SSRB published an *Initial report on public sector senior remuneration* in March 2010²⁷ which included a draft Code of Practice to provide guidance to those responsible for setting senior pay. The draft Code was intended to apply to all senior public sector executives and, in principle, to anyone earning more than £100,000 a year, which would include many medical and dental consultants.
- 4.69 We are also required, under the terms of reference,²⁸ to link our review to the *Hutton review of fair pay in the public sector*, which published its final report in March 2011.²⁹ The report was strongly in favour of performance pay for senior staff in the public sector:

“Executives have the autonomy and discretion to influence outcomes in a way that frontline staff may not. This makes it easier to link individual performance to organisational goals which are generally easier to measure and benchmark.”³⁰

²⁶Karen Bloor and Alan Maynard. Rewarding healthcare teams. *British Medical Journal* 316, February 1998: 569.

²⁷Review Body on Senior Salaries. *Initial report on public sector senior remuneration*. Cm 7848. TSO, March 2010. Available from: http://www.ome.uk.com/Initial_Report_on_Public_Sector_Senior_Remuneration_2010_PSSR.aspx

²⁸The full terms of reference for the review are given in Appendix A.

²⁹Will Hutton. *Hutton review of fair pay in the public sector: final report*. March 2011. Available from: http://www.hm-treasury.gov.uk/indreview_willhutton_fairpay.htm

³⁰Will Hutton. *Hutton review of fair pay in the public sector: final report*. March 2011: para. 3.13. Available from: http://www.hm-treasury.gov.uk/indreview_willhutton_fairpay.htm

- 4.70 The report proposed a Fair Pay Code, building on the SSRB draft Code of Practice on senior pay. It also advocated the use of 'earn-back pay' for senior public servants, whereby executives would have an element of their basic pay that needed to be earned back each year through meeting pre-agreed objectives; excellent performers who went beyond their objectives should be eligible for additional pay.³¹
- 4.71 *We agree with the need to not only reward good performance, but for any performance scheme to feature equivalent downside risks for poor performance. These principles can be taken forward in local award schemes in particular (see Chapter 5), though we stress that for any performance system to work well, a robust and fair system for judging performance is required.*
- 4.72 *The government will decide how to implement both the Hutton review of fair pay, and the SSRB work on public sector senior remuneration. We will consider how these reviews affect our remit groups in our future reports, when the government has indicated how the recommendations are to be implemented.*

³¹ Will Hutton. *Hutton review of fair pay in the public sector: final report*. March 2011: Recommendation 7. Available from: http://www.hm-treasury.gov.uk/indreview_willhutton_fairpay.htm

CHAPTER 5 – LOCAL (EMPLOYER-BASED) AWARDS

- 5.1 We are required by the terms of reference¹ for the review to reassess the structure of and purpose for the award schemes and provide assurance that any system for the future includes a process which is fair, equitable and provides value for money. In this chapter we consider the issues surrounding local (employer-based) award schemes. A table showing the main features of the various award schemes is at Appendix E. The history and purpose of awards is addressed in Chapter 2.
- 5.2 Table 5.1 shows the number and percentage of consultants holding a local award at each level of payment. In general, progressively fewer awards are made as the level of payment increases; however, this relationship does not hold for the highest level of local Clinical Excellence Award in England, or Discretionary Point in Scotland.

Table 5.1: Local awards held by consultants and clinical academics, 2010

Local Clinical Excellence Award/ Discretionary Point/ Commitment Award	England		Scotland		Wales		Northern Ireland	
	No.	%	No.	%	No.	%	No.	%
Level 1	3,225	8.1%	404	8.0%	469	19.7%	140	9.7%
Level 2	3,097	7.7%	399	7.9%	220	9.3%	108	7.5%
Level 3	2,293	5.7%	291	5.7%	127	5.3%	86	6.0%
Level 4	1,833	4.6%	273	5.4%	103	4.3%	64	4.5%
Level 5	1,479	3.7%	223	4.4%	72	3.0%	53	3.7%
Level 6	1,163	2.9%	176	3.5%	60	2.5%	41	2.9%
Level 7	954	2.4%	130	2.6%	32	1.3%	22	1.5%
Level 8	745	1.9%	203	4.0%	53	2.2%	11	0.8%
Level 9	1,203	3.0%	n/a	n/a	1	0.0%	4	0.3%
Total	15,992	39.9%	2,099	41.4%	1,137	47.9%	529	36.8%

Sources: ACCEA, SACDA, WAG and DHSSPSNI.

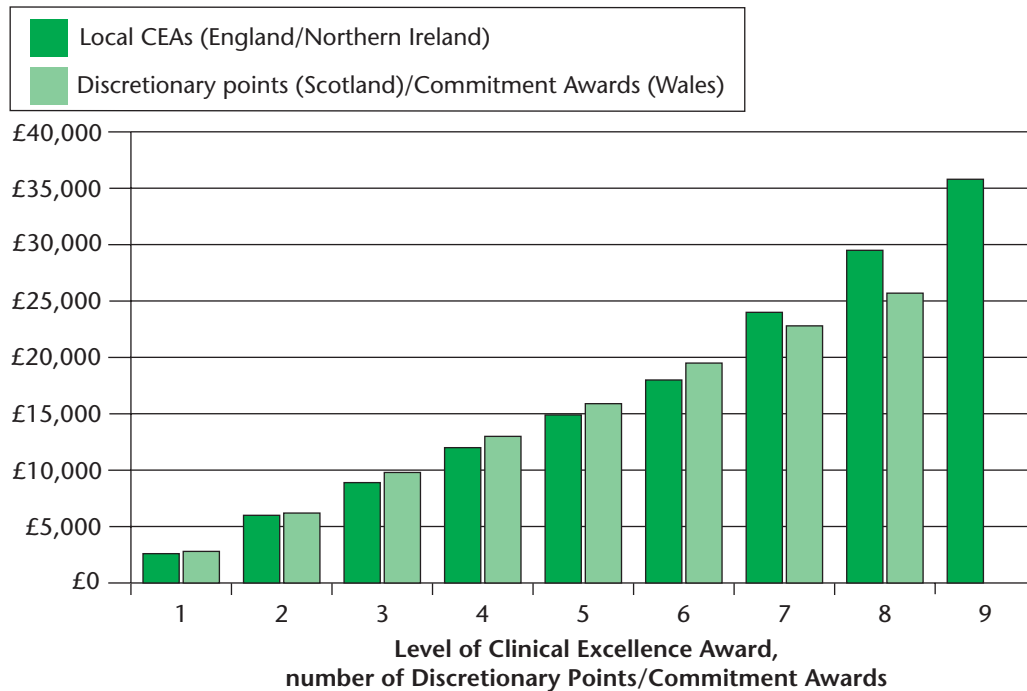
Level 9 awards are not awarded at local level in Northern Ireland.

There is one level 9 award in Wales. The Welsh Assembly Government explained that this could be because a consultant with a level 9 award moved from England to Wales (they are not available to consultants in Wales).

- 5.3 Figure 5.1 shows the value of local awards in each country. Some consultants in England and Northern Ireland continue to receive Discretionary Points, the values of which are identical to those in Scotland.

¹ The terms of reference for the review are given in Appendix A.

Figure 5.1: Value of local awards, April 2011



Note: level 9 CEAs are not awarded at local level in Northern Ireland.

England: Local Clinical Excellence Awards

5.4 In England, the current Clinical Excellence Award scheme was introduced alongside the new consultant contract in 2003. There are nine levels of local Clinical Excellence Awards: the number of consultants in receipt of local awards and their value are shown in Table 5.1 and Figure 5.1. Level 9 awards are subject to review: levels 1 to 8 are not. Consultants are eligible to apply for Clinical Excellence Awards after one year in post: the British Medical Association said it was important to retain this aspect of the scheme as it encouraged excellence at an early stage and inculcated a habit of continually seeking opportunities to excel. NHS Employers, however, thought that one year was too short a time to demonstrate sustained levels of performance and commitment. Leeds Teaching Hospitals NHS Trust said that all levels of Clinical Excellence Award should be subject to review, and that there should be a gap of one or two years before eligibility for a higher award applied. One individual thought current eligibility was too early and suggested that consultants should not be eligible to apply for a local Clinical Excellence Award until they had been in post for five years, and that following an award, they should not be able to apply for a higher award for two or three years. Furthermore, they thought that local awards should be capped at level 6 to create a gap between local and national awards.

Scotland: Discretionary Points and Scottish Consultants' Clinical Leadership and Excellence Awards

5.5 In Scotland, local awards are called Discretionary Points and are administered by Health Boards. All consultants who have reached the fifth point of the pay scale (currently £83,829) are eligible for consideration provided they have demonstrated an above-average contribution in respect of one or more specific areas such as service to patients, teaching, research and management of the service. The Discretionary Points scale contains eight points which range from £3,204 to £25,632 per annum. Once awarded, Discretionary Points are paid to individual consultants until they retire, are awarded additional points or receive a national Distinction Award. There is no process for review of

these annual additional payments. The number of consultants currently in possession of Discretionary Points is shown in Table 5.1 and their value is shown in Figure 5.1.

- 5.6 The Scottish Government told us that under its proposed new system of Scottish Consultants' Clinical Leadership and Excellence Awards (SCCLEA), it planned to expand the current Discretionary Points scale to include a further two points which would have different criteria from the existing eight points, but which would be decided at a local level. The proposed values of the new awards are shown in Appendix E. The Scottish Advisory Committee on Distinction Awards (SACDA) said that the profession had welcomed the proposed move to incorporate more local decision-making and the wider distribution of awards across the consultant population.

Northern Ireland: Local Clinical Excellence Awards

- 5.7 The Northern Ireland Clinical Excellence Awards scheme was introduced in 2005 and reviewed in 2008. The Northern Ireland Clinical Excellence Awards Committee (NICEAC) told us that the scheme was established following a wide-ranging consultation process and replaced the Distinction and Meritorious Services Awards scheme that had been in operation previously.
- 5.8 The scheme is a single, graduated scheme that comprises both local and regional elements. Lower awards (steps 1 to 8) are made by local (employer) committees and primarily reward outstanding contributions to local service delivery objectives and priorities. Consultants who have served three years are eligible to apply for a local award. The value of the awards is shown in Figure 5.1.

Basic salary scales in England, Scotland and Northern Ireland

- 5.9 The value of Clinical Excellence Awards and Discretionary Points are in addition to basic salary. The basic salary scales for consultants in England, Scotland and Northern Ireland for the 2003 contract are set out in Table 5.2.

Table 5.2: Basic salary scales in England, Scotland and Northern Ireland, April 2011

Pay point	Value (£)
Year 1	74,504
Year 2	76,837
Year 3	79,170
Year 4	81,502
Years 5 to 9	83,829
Years 10 to 14	89,370
Years 15 to 19	94,911
Year 20 onwards	100,446

Wales: Commitment Awards

- 5.10 In Wales, all consultants are working under the new consultant contract that was implemented in 2003, as, unlike the other United Kingdom countries, compulsory transfer to the new contract formed part of the acceptance conditions when consultants employed in Wales voted to agree their new terms and conditions.
- 5.11 Unlike the other countries of the United Kingdom, Wales does not have any local award schemes for its consultants. Instead, it has implemented a system of Commitment Awards. Consultants employed in Wales are first eligible to receive a Commitment Award

once they have completed three years of further service after they reach point 7 on the consultant pay scale. Subsequently, additional Commitment Awards are made at three-year intervals. A total of eight Commitment Awards are available to each consultant as a part of their contractual terms and conditions of service. Table 5.3 shows the salary scale and Commitment Awards for consultants employed in Wales.

Table 5.3: NHS Wales consultant salary scale and Commitment Awards, April 2011

Pay point	Value (£)
Year 1	72,205
Year 2	74,504
Year 3	78,350
Year 4	82,818
Year 5	87,918
Year 6	90,827
Year 7	93,742
Commitment Awards	
1	3,204
2	6,408
3	9,612
4	12,816
5	16,020
6	19,224
7	22,428
8	25,632

- 5.12 The Wales Awards Committee told us that the aim of Commitment Awards was to encourage consultants to achieve satisfactory outcomes for the benefit of the service. They are linked to satisfactory annual appraisals. The Committee commented that the overwhelming majority of consultants in Wales achieved Commitment Awards on a regular basis, and that they provided a graduated system of salary enhancements that run through much of most consultants' careers in recognition of their satisfactory service. The Committee said that, in effect, Commitment Awards were one component of the governance arrangements for promoting consultants' continuing satisfactory practice.
- 5.13 The Medical Women's Federation said that it believed the monies for local awards in England would be better allocated as in Wales, as a Commitment Award with equity for all, rather than continue with the current local Clinical Excellence Award system. It considered the system to be flawed due to the widespread variation in the way that employer-based awards were distributed and was concerned about the equity of local Clinical Excellence Awards for female doctors. One of the individual respondents commented that they thought there was much to commend the system used in Wales whereby Commitment Awards were given at three-yearly intervals instead of the current local awards system in England. Another, however, believed that the Welsh system did not seem to encourage new consultants to take on important and crucial roles in the NHS: they feared that the change in attitudes in new doctors regarding taking on any added work without pay would lead to major problems with important committee work. NHS Employers said that some employers thought that Clinical Excellence Awards could be scrapped and replaced with five-yearly increments for those who met acceptable performance standards. However, they did not advocate such a move as it might have implications in employment law in relation to equal pay.

5.14 *While we acknowledge the right of Wales to implement a system of Commitment Awards in place of a local award scheme, we are not recommending that the other countries of the United Kingdom adopt a similar model. Indeed, during oral evidence we explored with the parties whether they wished to pursue such a model, and they were all very clear that they did not wish to follow the Welsh approach. We understand that one of the reasons for Wales introducing a system of Commitment Awards was to act as a tool to improve retention of consultants: while retention in Wales does appear to have improved, it is also the case that retention has improved across the United Kingdom. It is therefore difficult to ascertain the extent to which the improvement in retention in Wales is due to Commitment Awards, as opposed to the other aspects of the new consultant contract, including improved pay. In the absence of any firm evidence on the benefits of Commitment Awards, we are unable to support a pay system that rewards length of service, in this case for up to 30 years, rather than the achievement of excellence.*

Funding of local schemes

5.15 The Department of Health's 2003 framework document on the new Clinical Excellence Awards scheme² stated that the annual level of investment in new awards at local level would be at least the same as would have occurred under the previous system of Discretionary Points. It said that the ratio of new local awards to eligible consultants would be a minimum of 0.35 a year.

5.16 However, the Advisory Committee on Clinical Excellence Awards (ACCEA) told us that the Department of Health had advised it that for the 2011 round, the ratio of new employer-based awards to eligible consultants should be changed to a minimum of 0.2 a year. It said that the Department had indicated that it had made this change to reflect the reduction in the number of national awards in 2010 and the tighter NHS financial circumstances. ACCEA told us that its role included monitoring that minimum investment requirements were met. It advised employers that any leftover funds from the minimum investment must be added to the following year's minimum investment.

5.17 In its evidence for this review, the Department of Health made further proposals. It referred to its White Paper *Equity and Excellence*³ that set out the government's long-term vision for the future of the NHS in England. The White Paper said that: "pay decisions should be led by healthcare employers rather than imposed by the government. In future, all individual employers will have the right, as foundation trusts have now, to determine pay for their own staff". It said that it wished to follow the spirit of the White Paper by leaving it to trusts to decide from 2012 whether or not to have award schemes which rewarded local leadership and management and that the existing central prescription about how to run local schemes would end. It believed that trusts should be able to choose whether or not to have a local scheme, the criteria for making awards and how much to spend on their scheme. It said that this approach would respond to the wishes of employers to have greater freedoms to design processes that reflected local priorities and considerations.

5.18 NHS Employers said that while they welcomed the reduction in the minimum local investment ratio, employers thought that there should not be a minimum spend at all. They believed that the current values of the awards were too high and that there were too many awards. They said that Local Awards Committees were seen as being fair and representative, but a criticism emerged in relation to the committees being effectively doctors agreeing to share out the available money rather than rewarding

² *The new NHS consultant reward scheme: Clinical Excellence Awards*. Department of Health, August 2003. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084129?ssSourceSiteId=ab

³ *Equity and excellence: liberating the NHS*. Department of Health, July 2010. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

excellence. They told us that the minimum spend should be removed and linked to the number of successful candidates or at least the number of applicants instead of the eligible consultants. Employers were also opposed to the awards being consolidated into basic pay so that additional Programmed Activities lead to further *pro rata* increases to the amounts in payment. NHS Employers said that any national descriptions of local schemes should be limited to allow the Boards and medical managers of the employing organisations to design processes which reflected local circumstances and priorities. They told us that the continued involvement of peer review could remain, but there needed to be a greater link of local awards to the objectives agreed in job plans. In response to the suggestion that local flexibility might simply lead to less investment in consultants, NHS Employers said that they were determined to retain, recruit and motivate the correct numbers and skill mix of staff to provide services for patients. It would therefore depend on a complex mix of factors which could only be properly considered at local level. They stated that they favoured DDRB setting out principles for any award scheme and recommending talks and negotiations between the parties about what scheme was actually agreed. The key thing for employers, they said, was to ensure that consultant doctors were fully engaged in the work of the trust. A large proportion of trusts recognised the need to support each other in a wider sense for the good of the whole service. NHS Employers told us that trusts would reflect this in any local scheme that emerged, but it would be desirable to provide local employers with clearer influence and involvement.

- 5.19 The Association of United Kingdom University Hospitals said that a revised local scheme could be more closely linked to the requirements and objectives of the local employer.
- 5.20 The British Medical Association told us that it continued to support local-level awards because they ensured that excellent consultants working in all types of hospitals and areas could be recognised. It said that the central monitoring of the distribution of local awards had been instrumental in moving towards a fairer system and it strongly cautioned against a move away from that.
- 5.21 Leeds Teaching Hospitals NHS Trust said that while it had consistently used the national guidance to arrive at the normal investment, in years where there was not the number of applications showing sufficient excellence, there was a tension around awarding the worthy applicants and the expectation of spending all the funding. It told us it would like funding to be linked to one year only and not a roll forward to the next year; and that the expectation should be to award excellence (to be defined) and not simply to spend all the money. It said that ring-fencing of funding for local awards should be considered.
- 5.22 The Scottish Government said that individual employers awarded Discretionary Points in line with a formula agreed in 2000, which meant that they awarded a minimum of 0.35 points per eligible consultant employed. However, it believed that it was arguably not credible that so many consultants received payments which supposedly rewarded exceptional performance. SACDA said that Scotland had imposed a freeze on all awards for the 2011-12 round: there would be no increase in the value of awards, no new awards created and no progression through the scheme. The Scottish Government said that in 2010-11, the budget for discretionary points was £31 million. Nicola Sturgeon, the Deputy First Minister and Cabinet Secretary for Health and Wellbeing, subsequently wrote to the parties to say that, after due consideration, she accepted that Discretionary Points payable in 2011-12 were paid in recognition of work done in 2010-11 and involved accrued contractual rights. However, she stressed that from 1 April 2011, there should be no expectation that work undertaken by consultants would count towards eligibility for Discretionary Points.

- 5.23 With regard to Northern Ireland, the British Medical Association told us that the funding allocation for Clinical Excellence Awards was initially set up so that there was no fixed ratio of awards per eligible consultant per year for a three-year period from 2005. New Clinical Excellence Awards were created only when Clinical Excellence Award money was released when a consultant holding Clinical Excellence Awards retired or died in service. The money for the released Clinical Excellence Award points was then returned for redistribution among eligible consultants. If there were no retirements of local Clinical Excellence Award holders in a particular year, then no new Clinical Excellence Award of any sort was funded. It said that no account was taken of increases in consultant head count. The British Medical Association told us that the ratio of receipt of new awards to eligible consultants was just 0.09, which it said compared very unfavourably with the rest of the United Kingdom. This funding arrangement created significant problems with the availability of Clinical Excellence Awards, and with consultant expansion meant that any Clinical Excellence Award points were spread ever more thinly.
- 5.24 In 2008, the Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) commenced a review of the Clinical Excellence Award scheme. The review recommended a minimum number of new awards each year based on a 0.25 formula of eligible consultants. However, DHSSPSNI told us that trusts had found it difficult to meet this requirement as the financial resources were not available. DHSSPSNI said it was its view that the award system must be equitable across trusts in Northern Ireland. It believed that whilst it was very useful to have a minimum number of awards made at local level to ensure continuity of the entire scheme, the 0.25 formula was unrealistic in the current economic climate. It said it was very difficult to justify the payment of Clinical Excellence Awards at the expense of bed, ward or service closures and that it was therefore its view that the minimum formula for awards at lower level should be removed. DHSSPSNI told us that for the 2010-11 awards round, it had taken the decision to make no new awards at local or regional level. It said its decision had been taken following consideration of the announcement of the two-year pay freeze for public sector workers earning more than £21,000 per annum, and in the light of the potential for further budgetary pressures arising from the Comprehensive Spending Review.
- 5.25 Only a few of the individuals who responded to our consultation commented that there were more local awards than were necessary, or supported the recent government decisions to reduce the minimum ratio of awards to the eligible population. One said that the number of awards could be a proportion of the number of applications rather than the eligible population and that local awards should be funded centrally: they said that Teaching Hospitals had a higher rate of national awards and so it cost them proportionately less to run the scheme than District General Hospitals who had more local awards to fund. One individual recorded their objection to the reduction in the minimum ratio, warning of the long-term damage to morale and the permanent loss of work 'above and beyond' contractual expectations.
- 5.26 A further suggestion for funding local awards put forward to us by an individual was that awards should be made annually, with the associated financial reward a lump sum rather than for life. They said that awards should be given to the top 10 per cent of consultants in a trust who had provided significant "value added" services that had impacted on patient care as measured by agreed quality metrics, and would reward the effective implementation of service developments. They suggested that employers should decide who the awards should go to, rather than the current system where consultants formed the majority of local Clinical Excellence Award committees.

- 5.27 Both the Dental Schools Council and the Medical Schools Council said they would support the possible abolition of local awards, to focus on excellence of true national significance, but it was absolutely vital that the national scheme be maintained. The Renal Association said that some of its correspondents suggested a reduction in the local award scheme with the reallocation of the money spent towards a regional award scheme or the extension of the national scheme.
- 5.28 *We have given much thought to the evidence provided by the parties on local award schemes. We have been struck by the large number of levels of local awards – nine in England, and eight in both Scotland and Northern Ireland, with Scotland proposing to introduce a further two levels. We do not believe it is necessary for there to be so many levels, which may lead to difficulties in assessing the incremental contributions of individual consultants. We set out in Chapter 4 our view that the current structure rewards length of service more than contribution or performance, and provides less of an incentive for job growth or development than we would expect, with, in practice, only a weak link to appraised performance. Near-automatic progression is not typically a feature of any of the professional roles we use for comparators at this level. We are also concerned that, with the exception of local awards in Northern Ireland and level 9 awards in England, local awards are not subject to any form of review, so there is no assessment of whether the contribution of individual consultants is being maintained. The only assessment appears to be when individuals apply for a higher level of local award.*
- 5.29 *It is apparent that the existing local award schemes and the job planning and performance appraisal processes were created separately, without any serious thought as to their integration. This stands out as an obvious flaw with the current system. For the future, we believe there should be a much stronger link between local awards and performance appraisals of consultants. It would no longer be appropriate for individual consultants to apply for local awards: employers should make decisions as to which of their consultants are the most deserving in any one year by an assessment of their job performance. We believe that job performance should be assessed on the basis of the knowledge, skills, expertise and competence that employees apply to the job, how they behave in carrying out their work, the results that employees achieve against both their employing organisation and individual objectives, and their impact on the employing organisation. The schemes should reward clinical excellence; the quality of outcomes; teaching, research and innovation; and the delivery of the employing organisation objectives for improving patient care, using objective measures such as patient outcomes and patient feedback, where appropriate.*
- 5.30 *Local award schemes should be competitive, with awards being made to the highest performing consultants, say, 25 per cent of consultants working within each employing organisation. As the awards are to be linked to job plans and objectives, we believe there is a strong argument for the associated awards to be one-off annual lump-sum payments, particularly as the setting of objectives normally relates to an annual cycle. There may be exceptional cases where the employing organisation considers that the achievement of objectives warrants an award for a period exceeding one year, perhaps when the benefits of the achieved objectives are felt over a prolonged period, although, in such a case, it could be dealt with by adjusting the size of the award. In any case, we believe that one-year local awards should be the norm, and that the maximum length of local award should be for three years in exceptional cases, to be paid in annual lump-sum payments. When payments are made over a period in excess of one year, it will be important that the performance level of recipients remains at an appropriate level, which should be confirmed by ‘sign-off’ from the employing organisation Chief Executive on an annual basis.*
- 5.31 *We acknowledge the concern that our proposal for annual one-off awards could suggest an additional administrative burden on employers. In response, we would simply say that if employers are already demonstrating best practice with regular job planning, objective setting and performance appraisal, then they should already have the tools to hand to enable them to deliver our proposed new local scheme.*

- 5.32 *As we envisage the new awards as one-off payments, then no issue arises over the ongoing payment of awards without review. For those consultants currently in receipt of local awards, we recognise that one of the accrued rights of such award holders is that they should be able to retain their award subject to satisfactory periodic review. In the future, we believe that all holders of existing local awards should have their awards reviewed regularly, the length of time between reviews to be determined by the awarding organisation, but with a presumption for annual reviews. Where appropriate, the reviews should allow for the possibility of the withdrawal or downgrading of awards. When the withdrawal or downgrading of awards does occur, subject to accrued rights, we do not believe that pay protection should apply.*
- 5.33 *Our detailed views on pension issues are set out in Chapter 8. With the changes we are recommending for the award schemes to make them non-consolidated and non-recurrent, we think it is no longer appropriate for awards to be pensionable.*
- 5.34 *The Department of Health said that it wanted to leave it up to individual employers whether or not to have local award schemes. While we are content for local employers to have discretion over decisions about local schemes, we stress the importance of all employing organisations having local award schemes in place to recognise the valuable contribution that consultants make towards delivering the objectives of employing organisations. We do have some reservations linked to the funding and affordability of such schemes, and suggest that consideration be given to agreeing a cap on the cost of local schemes. We believe that decisions on local schemes should take place within a United Kingdom-wide framework of common principles and governance.*

Recommendation 2: For local award schemes, we recommend that such schemes should operate within a United Kingdom-wide framework of common principles and governance and should include the following:

- all employing organisations should have a local award scheme in place;
- there should be measurable targets linked to both the objectives of the employing organisation and the individual objectives of consultants;
- the system should be transparent, fair and equitable;
- awards should be linked to performance appraisals and should be made only for work that is done over and above job plans;
- awards should not reward activity already remunerated elsewhere, for example through additional Programmed Activities or Supporting Professional Activities, unless the outcomes are significantly above expectations;
- consultants should no longer need to apply for local awards – all would be eligible. Employing organisations should make decisions as to which of its consultants were the most deserving in any one year;
- schemes should operate within a competitive environment, to reward a limited percentage of consultants working for an employing organisation within any one year;
- nationally, the parties should agree a cap on the cost of local schemes;
- under the new schemes, local and national awards may be held simultaneously;

- awards should be non-consolidated and non-pensionable;
- one-year local awards should be the norm, and the maximum length of local award, in exceptional cases, should be three years, to be paid in annual lump-sums;
- awards in excess of one year should require 'sign-off' by the employing organisation Chief Executive on an annual basis;
- all existing award holders should have their awards reviewed on a regular basis, the awarding organisation to decide the length of time between reviews (but with a presumption for annual reviews) and with no grace period;
- subject to accrued rights, there should be no pay protection; and
- subject to accrued rights, consultants who retire and return to work should not retain any local award, although they should be eligible for consideration for new local awards alongside other consultants.

5.35 *We recognise that there will be a number of detailed issues arising from our recommendation on a United Kingdom-wide framework of common principles and governance for local schemes: for example, the number of levels of local awards, the number of consultants in receipt of awards and the value of individual awards. NHS Employers has indicated that it believes that the fine detail of the new scheme should be left for it to negotiate with the parties and we are content with that proposal. England, Wales, Scotland and Northern Ireland will each need to consider how they wish to take forward our recommended framework to reflect their particular circumstances: we note that not every country is looking for local flexibility for local schemes, but observe that our recommended framework for local awards could apply equally to a national scheme within each country. If Wales were to adopt our recommended model for local awards, it would need to give thought as to how such a scheme would interact with its existing pay scale and Commitment Awards. We do not think it appropriate for consultants to receive both local awards and Commitment Awards, but if Wales wished to relinquish Commitment Awards, then it would probably need to reconsider the pay points for its main consultant pay scale, as its current pay scale appears to build in assumptions on progression using Commitment Awards.*

5.36 *As the details of any future local schemes are to be determined through negotiation, we are not in a position to comment on the overall affordability of the schemes, although we note that as we are recommending that awards should no longer be pensionable, this will have a significant impact on their cost. We have also suggested that local award schemes should operate in a competitive way, with awards going to, say, the highest performing 25 per cent of consultants, and that there should be a cap on the cost of local schemes. We set out an example in Chapter 10 how we envisage a local scheme might operate, with four levels of award, to be given to 25 per cent of consultants in each year. We estimate that, on average, consultants would receive approximately 4.1 per cent of their basic salary as a lump sum – which equates to approximately 2.6 per cent of the total consultant pay bill. This would release funding which, together with funds released from the national awards scheme, would be sufficient to enable the creation of the principal consultant grade that we describe in Chapter 4. Our suggestion for how a local scheme might operate is not intended to be binding on the parties, but is to illustrate the affordability of such an arrangement.*

5.37 *It will be important for us to be able to continue to monitor the amount of funding that is being channelled into local award schemes, as this forms an essential part of our wider work on pay comparability. We recognise that this will not be as simple as at present, particularly if employers set up their own local award schemes in the future. We therefore ask the Health Departments to set up mechanisms, where necessary, so that they are able to report back to us on an annual basis the level of funding for consultants' local award schemes. We would expect this information to form part of the normal submission of annual evidence to us.*

Recommendation 3: We recommend that the Health Departments provide annual evidence to DDRB on the level of funding for local award schemes.

5.38 *We set out in Chapter 10 how, when consultants leave the NHS, some of the funding for existing national awards should be transferred to employing organisations, to add to the funding for the new local schemes and implementation of the new principal consultant grade. Recommendation 14 in Chapter 10 addresses this issue.*

5.39 *Our recommendation on a United Kingdom-wide framework of common principles and governance states that local award schemes should be transparent, fair and equitable. As the design of local schemes will, in future, be largely for employing organisations to decide, they will need to give particular attention to this principle. We would expect all employing organisations to publish data on the awards made annually and details of their local award schemes. These data should be provided to the national database and recorded in a consistent manner across NHS organisations, to enable monitoring, auditing and analysis.*

Recommendation 4: We recommend that employing organisations publish annual data on the awards made and details of their local award schemes.

CHAPTER 6 – NATIONAL AWARDS

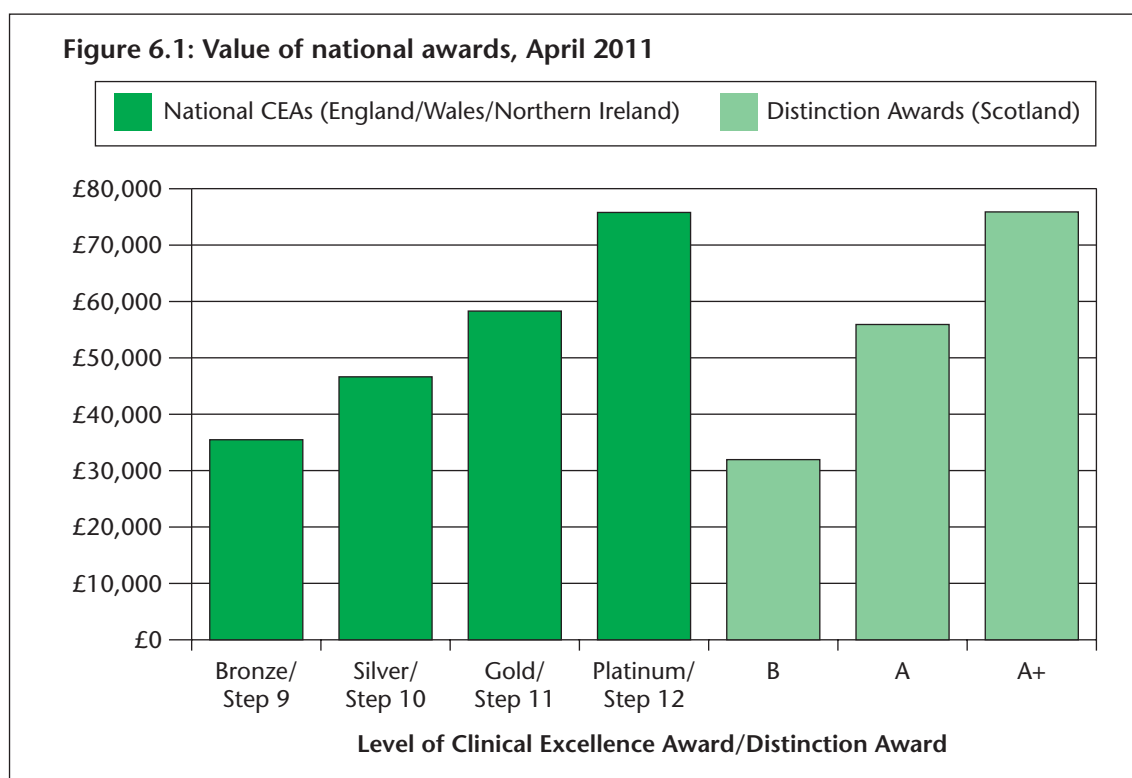
- 6.1 We are required by the terms of reference¹ for the review to reassess the structure of and purpose for the Clinical Excellence and Distinction Awards schemes and provide assurance that any system for the future includes a process which is fair, equitable and provides value for money. In this chapter, we consider the issues surrounding national awards. A table showing the main features of the various award schemes is at Appendix E. The history and purpose of the awards system is addressed in Chapter 2.
- 6.2 Table 6.1 shows the number and percentage of consultants and clinical academics holding a national award at each level of payment. For ease of comparison across administrations, awards with similar cash values have been grouped together. In each scheme, progressively fewer awards are made as the level of payment increases.

Table 6.1: National awards held by consultants and clinical academics, 2010

National CEA/ Distinction Award	England		Scotland		Wales		Northern Ireland	
	No.	%	No.	%	No.	%	No.	%
Bronze/B	2,250	5.6%	359	7.1%	135	5.7%	44	3.1%
Silver	786	2.0%	n/a	n/a	39	1.6%	37	2.6%
Gold/A	563	1.4%	166	3.3%	26	1.1%	14	1.0%
Platinum/A+	269	0.7%	53	1.0%	10	0.4%	5	0.3%
Total	3,868	9.7%	578	11.4%	210	8.8%	100	7.0%

Sources: ACCEA, SACDA, WAG, DHSSPSNI, Medical Schools Council.

- 6.3 Figure 6.1 shows the value of national awards in each country. Some consultants in England, Wales and Northern Ireland continue to receive Distinction Awards, the values of which are identical to those in Scotland.

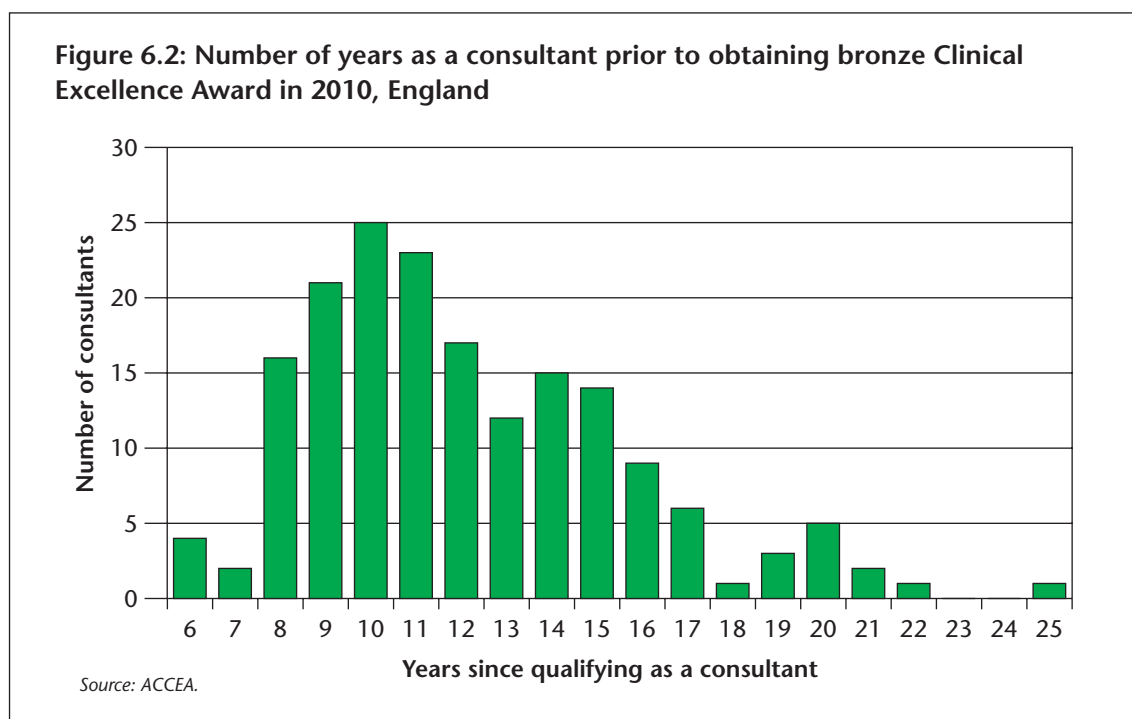


¹ The terms of reference for the review are given in Appendix A.

England and Wales: Clinical Excellence Awards and Distinction Awards

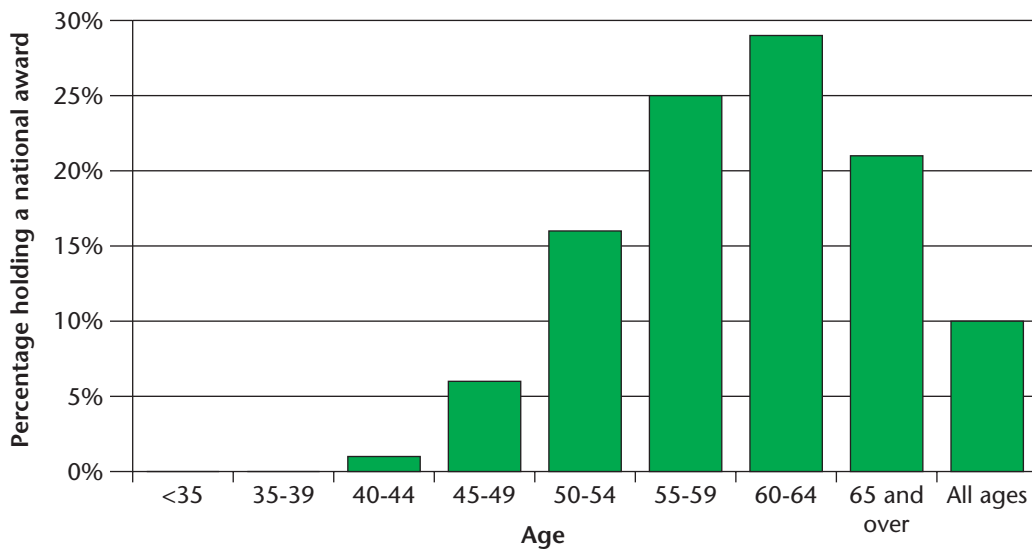
6.4 The current Clinical Excellence Award scheme was introduced alongside the new consultant contract in 2003. There are four levels of national award: bronze, silver, gold and platinum. The Advisory Committee on Clinical Excellence Awards (ACCEA) makes recommendations to Ministers on the national awards. Significant numbers of consultants (28 per cent of national award holders) are still receiving Distinction Awards, which is the scheme that preceded the current scheme before 2003. These awards are at levels B, A and A+. National awards are currently subject to review at five-yearly intervals. Consultants in England generally progress through the local Clinical Excellence Award scheme before moving on to national awards; in Wales, as described in the previous chapter, Commitment Awards are used instead of a local Clinical Excellence Award scheme – any consultant employed in Wales who is successful in applying for a national Clinical Excellence Award loses any Commitment Awards that they have accumulated previously, and they also lose any further eligibility for Commitment Awards. ACCEA’s guidance says that if a consultant holds Discretionary Points, a local Clinical Excellence Award (level 1 to 8), a Commitment Award (in Wales) or (exceptionally) no award, then they are eligible to apply for a national bronze award. To be eligible for a silver award, a consultant must hold a bronze award, a local level 9 Clinical Excellence Award or a B Distinction Award; for a gold award, a consultant is eligible if they hold a silver award; and for a platinum award, a consultant must hold a gold award or an A Distinction Award. Figure 6.1 shows the value of national awards.

6.5 National awards are made for sustained excellent contributions to the NHS. It follows that they are more likely to be awarded to consultants with a number of years’ experience. Figure 6.2 shows that very few consultants were awarded a bronze Clinical Excellence Award in 2010 prior to gaining eight years’ experience as a consultant; the median length of service prior to being awarded a bronze Clinical Excellence Award was 11 years.



6.6 In the United Kingdom as a whole, less than 10 per cent of consultants and clinical academics held a national award in 2010; however, there is wide variation by age. Less than 10 per cent of consultants and clinical academics aged under 50 held a national award in 2010, with the proportion rising to 29 per cent in the 60 to 64 age group (Figure 6.3).

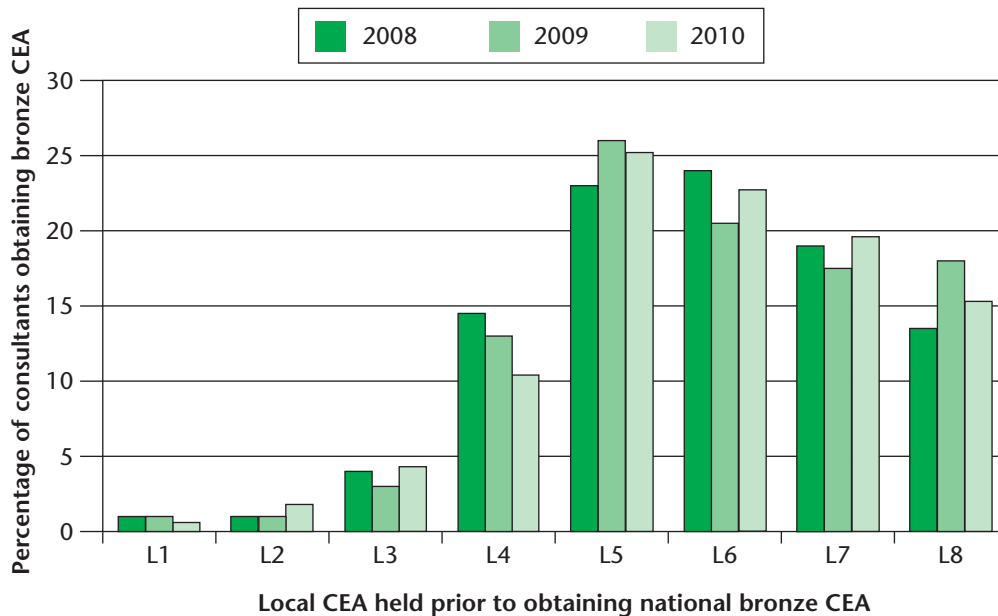
Figure 6.3: Percentage of consultants and clinical academics holding national awards, by age cohort, United Kingdom, 2010



Source: NHS Information Centre, ACCEA, SACDA, WAG, DHSSPSNI, Medical Schools Council.

6.7 In England, bronze Clinical Excellence Awards tend to be awarded to consultants who have already obtained at least a level 4 local Clinical Excellence Award, with a median of level 6 (Figure 6.4). For individuals progressing from local to national award, the increase in pay ranges from £5,914 to £32,527, with a median value of £17,742 in 2010.

Figure 6.4: Local Clinical Excellence Awards held by consultants prior to obtaining a national bronze Clinical Excellence Award, England



Source: ACCEA.

Scotland: Distinction Awards and Scottish Consultants' Clinical Leadership and Excellence Awards

- 6.8 In Scotland, national awards are called Distinction Awards, and are operated through a non-departmental public body - the Scottish Advisory Committee on Distinction Awards (SACDA). SACDA was set up in 1998 to replace the previous United Kingdom body and to act on behalf of Scottish Ministers in deciding which medical and dental consultants in Scotland should receive Distinction Awards. There are three levels of Distinction Awards: B, A and A+. All awards granted from the 1989 awards round onwards are subject to five-yearly review to ensure that each award holder continues to meet the criteria appropriate for a Distinction Award. SACDA's guidance says that there is no lower age limit at which consultants may apply for or receive an award, but they will normally be expected to have ten years' experience at consultant grade before applying for a B award. Those applying for an A award will normally be expected to have held a B award for five years. Those applying for an A+ award will normally be expected to have held an A award for five years. These are not, however, strict rules: each application is considered on merit. The values of Distinction Awards are shown in Figure 6.1.
- 6.9 The Scottish Government told us that, under its proposed new system of Scottish Consultants' Clinical Leadership and Excellence Awards (SCCLEA), it planned to replace SACDA by a new body, the Scottish Advisory Committee on Consultant Clinical Leadership and Excellence Awards (SACCCLEA) who would recommend awards at national level (grades 11 to 13). The proposed values of the new awards are shown in Appendix E.

Northern Ireland: Clinical Excellence Awards

- 6.10 The Northern Ireland Clinical Excellence Awards scheme was introduced in 2005 and reviewed in 2008. The Northern Ireland Clinical Excellence Awards Committee (NICEAC) told us that the scheme was established following a wide-ranging consultation process and replaced the Distinction and Meritorious Services Awards scheme that had been in operation previously.
- 6.11 The scheme is a single, graduated scheme that comprises both local and regional elements. Higher awards (steps 9 to 12) are recommended by NICEAC to the Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI). For these awards, contributions at a regional, national and international level are important. NICEAC told us that step 9 awards were recently moved to the regional award section because of problems with local awards, but that it intended to review this decision when the local awards had settled into an appropriate pattern. NICEAC guidance says that, for higher awards, consultants must have achieved a minimum of four lower Clinical Excellence Awards or four Discretionary Points to become eligible. NICEAC considers that, in most cases, it would normally take at least ten years for consultants applying for a step 9 award to accumulate the quantity and quality of evidence necessary to justify an award, though in exceptional cases faster progression is possible. NICEAC also would expect in most cases at least four further years to justify progression beyond step 9. The values of the awards are shown in Figure 6.1.

Proposals to change the schemes

- 6.12 We received a number of proposals on how the national schemes might be amended.

Review of awards versus new application

- 6.13 The Department of Health said that awards were made on the basis that they have to be reviewed every five years. It suggested that this provision should be changed to a need to reapply, and that consultants should demonstrate a continued standard of excellence in

open competition with new candidates. It said that the timescale for needing to reapply merited careful consideration including a cost-benefit analysis, but that the presumption should be for annual reapplications in line with the timescales for performance-related pay in the public sector. It told us that under the current ACCEA rules, consultants must submit to review every five years, and that reviews were considered, but not scored, by regional sub-committees and the Chair and Medical Director of ACCEA. Consultants who failed to submit, or submitted an inadequate review in the appropriate year, were granted one year's grace. It said that, during this year, the consultant continued to hold the award, receiving the cash value of the award in their pay, including any increase in the value of the award. Only after failing to submit or submitting an inadequate review the following year was the review deemed as a failed review and the award withdrawn by ACCEA. The Department of Health proposed that the year's grace should be removed: failure to submit the initial review should lead to the immediate withdrawal of the award, and submission of an inadequate review from the 2012 round should lead to the award being withdrawn.

- 6.14 The Department of Health later supplied us with a copy of its cost-benefit analysis on changing the renewal period for national awards. It argued for the period of awards to be annual, to allow ACCEA to clearly identify those consultants who were currently excellent, rather than continuing awards for achievements in years gone by. It estimated the cost of this option to be some £10.8 million annually, but that if changes were made, such as the streamlining of the system of committees making assessments, the removal or reduction of the burden on National Nominating Bodies and specialist societies, and the discontinuation of bronze awards at national level, funds would be released in both direct and hidden terms.
- 6.15 The Welsh Assembly Government said that award holders should have to demonstrate a continued standard of excellence in competition with new applicants.
- 6.16 The DHSSPSNI told us that any new awards scheme should provide for one-off cash payments which were not consolidated.
- 6.17 NHS Employers said that awards at level 7 and above should be open to five-yearly review or re-application. In supplementary evidence, they told us that employers supported a system of regular reapplications rather than reviews, but that decisions on local schemes should be for local determination. NHS Employers said they did not like the current year of grace arrangement. They also expressed concern over the potential administrative burden of more applications: reduced time cycles might have to be accompanied by significant simplification of processes and less external scrutiny.
- 6.18 ACCEA said it had a concern that some consultants who had had their awards renewed would be unlikely to be competitive when considered against new applications and that, with funding restraints, this meant that new, better applications might go unrewarded. It told us that, for the 2011 round, it would be piloting a process for considering reviews against standards for new awards. It suggested that time-limited awards of five years' duration might provide a solution: consultants would then be able to submit a new application to be judged in competition with other applications at that time. ACCEA provided supplementary evidence to us on its analysis of the scoring of renewals in the 2011 round: it showed that of the 364 bronze and B renewal applications considered, 53 per cent met the minimum scoring of successful new bronze applications; applications being considered for progression to a new higher award were generally of a higher standard than exhibited by those applying for renewal only, which ACCEA said was due to an element of self selection whereby the best renewal applicants were attempting to progress to a higher level of new award, but that there might also be an element which reflected less attention being given to renewal applications if not accompanied by a new application. ACCEA noted that the scores from its analysis should not be taken as

an indication of the failure or otherwise of renewals in 2011, as the scores were used by ACCEA to indicate which renewals required further discussion and would be mediated by consideration of previous contributions.

- 6.19 In response to the Department of Health's supplementary evidence on its proposal for annual reviews of national awards, ACCEA said that the objective of the current scheme was intended to ensure that consultants were retained in the NHS, and sought to reinforce and incentivise excellence, with an emphasis on the evidence of sustainability. It also stressed that there would be significant administrative costs in moving to a system of annual reviews.
- 6.20 SACDA recommended that awards should be held for a limited time, perhaps three or five years, with re-application rather than review.
- 6.21 The Ministry of Defence, discussing its own Clinical Excellence Award scheme, said it would like to see a more dynamic approach to the management of individuals, so that they could move up and down the scale and would receive the requisite payment for each level. All applicants would be assessed on a level playing field with new and renewing applicants in competition with each other. Where a renewing applicant did not reach the level of a new applicant, the award would be downgraded or removed without pay protection. It also thought that the current five-year fixed term could be reduced to provide more opportunities for new awards and movement up and down the scale.
- 6.22 The Academy of Medical Royal Colleges said it fully supported the principle of regular reviews of awards, and that the standards for approving the continuation of an award should be no less rigorous than those applied for giving the award in the first instance. The Royal College of Obstetricians and Gynaecologists told us that the process needed to be responsive to changing circumstances, with the capacity to reconsider awards in a timely fashion.
- 6.23 The Academy of Medical Sciences, British Heart Foundation, Cancer Research UK and the Wellcome Trust, in their joint submission, said that awards should continue to be made for five years, but that renewal should be on a competitive basis requiring fresh evidence of outstanding contributions. One of the individual responses we received also proposed that awards should have a finite life (they suggested three to five years) after which a new application for an award would have to be made, to be assessed exactly as others for the relevant year. Another suggested that a piece of work that did not have successive work built on it leading to an even greater achievement should not be rewarded for five years, but that a three-year review was more appropriate.
- 6.24 The British Medical Association said that the reviewing of level 9 local awards had recently been introduced and that, if successful, the process of review might be extended to other levels of award in the future. It told us that it was important to reward and encourage sustained commitment and excellence, and the review process, when applied properly, ensured that ongoing payment only happened when there was evidence of sustained contribution. However, the British Medical Association also said that forcing a large swathe of re-applications each year would be excessively bureaucratic and burdensome. It believed that ongoing reward rather than one-off bonuses encouraged commitment and continuing excellence throughout a career, and that bonuses could encourage patchy delivery of short-term excellence which could be de-stabilising for the NHS. It also said that fixed-term awards would have a significantly reduced effect to incentivise consultants to excel and could lead to a 'good enough' culture instead of an aspiration to excellence. It suggested that fixed-term awards might also provide the perception of a 'bonus culture', which was unacceptable in the current climate. The British Medical Association said that the granting of a fixed-term award created

a separate difficulty in obtaining an award at a greater level: how would a consultant progress up the scale?

- 6.25 *While we note the caveats attached by ACCEA to its analysis of the scoring of renewals in the 2011 Round, we nevertheless note that it shows that of the 364 bronze and B renewal applications considered, 47 per cent did not meet the minimum scoring of successful new bronze applications. ACCEA also raised its concerns that, with funding restraints, new and better applications might go unrewarded. We set out in Chapter 5 a United Kingdom-wide framework of common principles and governance that we believe should apply to local award schemes. We believe that many of those principles and governance arrangements should also apply to any national award schemes. Our recommendation on the principles and governance for a national award scheme appears later in this chapter, and includes our belief that national awards should be held for a period of up to an absolute maximum of five years. The duration of an award should be decided by the awarding body at the time the award is made, and should be related to the sustainability of the achievement being rewarded, rather than based on administrative simplicity. We also consider it important that recipients of national awards are also meeting the objectives of their employing organisation. We therefore believe that it should be a requirement that all national award holders receive 'sign-off' from the Chief Executive of their employing organisation. This 'sign-off' should be provided on an annual basis to cover the length of any national award. Consultants should be free to make a new application for an award at any time. We believe that this should help to ensure that only the most deserving consultants are in receipt of an award at any point in time. We note the comments from both the Department of Health and NHS Employers that they do not support the current arrangements, whereby reviews of awards can be given a year's grace: under our recommended new framework for national awards, this would not arise. Awards would be for a fixed period, after which payment would cease. For existing awards that will remain subject to review, we agree that there should not be any grace period.*
- 6.26 *The Department of Health made some suggestions as to how the costs of running the scheme could be reduced if a system of one-year awards was moved to, including the streamlining of the system of committees making assessments and the removal or reduction of the current burden on National Nominating Bodies and specialist societies. It would appear to us that similar changes, with the associated savings, could be made to the national awards system, regardless of the length of awards.*

Eligibility for awards

- 6.27 The joint submission from the Academy of Medical Sciences, British Heart Foundation, Cancer Research UK and the Wellcome Trust said that there should not be any requirement to have achieved a threshold level of local awards before being eligible for consideration of a national award, although ACCEA subsequently confirmed to us that there was no such requirement in England. One individual commented that consultants should not be eligible to apply for a bronze award until they had been in post for ten years, and not eligible to apply for a subsequent award in less than four years. The British Society of Periodontology thought there should be an absolute minimum five-year gap before applying for a new national award. The Royal College of Radiologists said that incentives should be spread over the course of a career, and that the current systems rewarded too soon and consequently the top awards could be reached very early in a doctor's career. The Committee of Postgraduate Dental Deans and Directors thought that greater clarity was needed on the eligibility rules for national awards, such as whether it was necessary to hold a local award.
- 6.28 *We set out later in this chapter a United Kingdom-wide framework of common principles and governance under which we believe a national award system should operate. We believe that applications for national awards should be via self-nomination, and that it should be the role of the awarding bodies to make an assessment of the applications and to rank them in order.*

Awards would be made based on the quality of applications and judged on their individual merits. It would therefore no longer be necessary for individuals to apply for a given level of award, although we think it would be helpful to applicants if the awarding bodies were to publish guidance on the criteria expected at each level of award. Furthermore, we do not see a need to restrict access to eligibility for national awards to any particular length of service: all consultants should be able to apply for a national award at any point in their career. Success or failure will be determined by an assessment of their applications relative to all others in any one year.

Pay protection

- 6.29 The Department of Health also drew our attention to the pay protection provisions of the current scheme. It said that, under the current system, individual consultants who had their awards withdrawn following a failed review received pay protection on a mark-time basis. It told us that this provision took effect in 1989 when five-yearly reviews were introduced, but it now considered the provision to be anomalous and that it intended to discontinue the practice. It said that if an award was withdrawn, the consultant should lose the cash value they had previously been receiving. This proposal had the support of a large number of bodies: the Academy of Medical Sciences, British Heart Foundation, Cancer Research UK and the Wellcome Trust, ACCEA, the Association of United Kingdom University Hospitals, the British Cardiovascular Society, the Conference of Postgraduate Medical Deans of the United Kingdom, the DHSSPSNI, the Medical Schools Council, NHS Employers, the North East Committee of ACCEA, the Royal College of Physicians, SACDA, the Scottish Government, St George's, University of London, the Universities and Colleges Employers Association, the Wales Awards Committee of ACCEA, the Welsh Assembly Government and the West Midlands Committee of ACCEA; and other bodies agreed that reviews should be more robust, including the British Association of Stroke Physicians, Leeds Teaching Hospitals NHS Trust, the London North East Committee of ACCEA, the Royal College of Physicians of Edinburgh and the Royal College of Radiologists. Individual responses also supported the removal of pay protection: one considered it anomalous that an individual could clearly not be doing the work for which they received a national award and yet continued to be paid the money as though they were doing the excellent work; one said the effect of the withdrawal was almost meaningless; and another submission noted that 'withdrawal of awards' should mean what it said.
- 6.30 In March 2011, the Chief Medical Officer for the Department of Health wrote to us to say that the Department intended to consult key stakeholders (including NHS Employers and the British Medical Association) with its proposal to remove the pay protection which individual consultants received on a mark-time basis when their awards were withdrawn by ACCEA.
- 6.31 The Ministry of Defence, which bases its Clinical Excellence Award scheme on that for the NHS, said that, for its Clinical Excellence Award scheme, pay protection performed a necessary function, as through the restriction of a military career, consultants could not carry out clinical duties 100 per cent of the time. Awards could be suspended for a short period, then re-assessed once the individual had been placed back into a clinical post. However, it said there were scenarios where it would be keen to be able to withdraw the award and related pay protection, such as when a consultant with an existing award applied for a renewal and clearly failed to demonstrate the required standard of excellence. It told us that the current system of indefinite pay protection appeared to contradict the ethos of the scheme.
- 6.32 ACCEA noted that approximately 0.7 per cent of its award budget was spent on honouring pay protection. While the British Medical Association acknowledged that it was rare for awards to be removed, and that even when this did occur, pay protection applied (by freezing awards at their current value), it argued that the perceived recurrence of awards was one justification for the comparatively low levels of Clinical

Excellence Awards as a percentage of basic salary and for the relatively small number of Clinical Excellence Awards at national level. It said that the removal of the permanence of Clinical Excellence Awards or an increase in the frequency of reviews should be accompanied by an increase in either the value or incidence of awards if the relationship between average consultant income and that of comparator groups was not to be disturbed. In supplementary evidence, the British Medical Association told us it was willing to consider the discontinuation of pay protection as part of an overall proposal, but that a reviewing committee could have a range of options open to it, including renewal of awards at a lower rate.

- 6.33 *We are required by our terms of reference to respect the accrued rights of individuals. The parties, however, were not able to provide us with an agreed definition of what those accrued rights are. The Department of Health does not list pay protection amongst its own interpretation of accrued rights, and is intending to carry out a consultation with key stakeholders on its proposal to remove the pay protection which individual consultants received on a mark-time basis when their awards were withdrawn by ACCEA. The British Medical Association has said that it believes pay protection to be an accrued right. If that is the case, other questions remain: does the accrued right to pay protection only apply to those consultants who have already had an award removed or downgraded, or does the mere ownership of an award afford pay protection for the future if that award is removed or downgraded? Ultimately, the extent to which pay protection is an accrued right is an issue for the parties to settle. However, subject to accrued rights, we agree that any future national scheme should not include any provisions for pay protection. We note that this would allow funds to be released for additional national awards for other applicants who meet the criteria.*

Bronze awards and level 9 local awards

- 6.34 The Department of Health also told us that it wished to address what it perceived to be a lack of clarity about level 9 and bronze awards, which both have the same cash value of £35,484. It said that level 9 awards were made by trusts for local contributions, and that national bronze awards were recommended by ACCEA for a mixture of local and national contributions. The Department told us that it recommended that from 2012, any awards at the equivalent level to the current level 9 or bronze should all be locally determined. One individual also suggested making bronze awards entirely the domain of trusts, and went on to say that they thought there should be a single level of national award, valued somewhere between bronze and silver. Another individual commented that once bronze level had been reached, there was no scope for further advancement without national contributions, and suggested that it should be possible to progress to a local silver award, funded centrally.
- 6.35 NHS Employers said that if something resembling the current scheme was retained, then it was appropriate for the higher locally-awarded amounts to be able to match the lower nationally-awarded amounts.
- 6.36 The British Medical Association told us that excellence and commitment could be delivered both locally and nationally and that both had potentially high value to the NHS. While there might be some benefit in distinguishing the awards, it said that there should not necessarily be a premium on national awards.
- 6.37 *ACCEA's 2010 Annual Report² provided some analysis of award trends, looking at the applicants who were successful in obtaining silver awards. The analysis showed that consultants holding employer-based level 9 awards had a lower success rate than bronze award holders when applying for silver awards: just 2.67 per cent of applications from level 9*

² Advisory Committee on Clinical Excellence Awards. *Annual report: covering the 2010 awards round*. ACCEA, November 2010: paras. 1.18-1.19. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@ab/documents/digitalasset/dh_121388.pdf

award holders were successful, compared with 16.8 per cent of bronze award holders. ACCEA concluded in its submission to us, as part of our normal 2011-12 round, that it appeared that two pyramids had emerged for national and employer-based awards and that it seemed likely that for many consultants, a level 9 award represented a ceiling. This evidence suggests that there is a strong need for the continuation of an entry-level award at national level. This will be particularly important, given that we are recommending the separation of the local and national award schemes. We set out our view in the previous chapter that the design of local award schemes should be left to local discretion, albeit within our recommended United Kingdom-wide framework of common principles and governance.

- 6.38 *A particular transition issue arises here. At present, level 9 award holders are not eligible to apply for bronze awards: just silver awards. Under our proposed new schemes, any consultant should be able to apply for a national award at any point in time: as previously described, success or failure will be determined by an assessment of the quality of the application. It may be, therefore, that a current level 9 award holder could be successful in receiving a new national award at a level equivalent to the current bronze award. However, subject to accrued rights, we believe that any consultant who moves onto the new award schemes should no longer retain any award held under the existing award schemes. Our recommendations on transition arrangements are contained in Chapter 10.*

Funding of national awards

- 6.39 We received a number of comments about the level of funding for national awards.
- 6.40 The Department of Health asked us to design and recommend new arrangements to properly compensate and incentivise consultants in future, and to recommend an affordable and appropriately tiered limit on the proportion of consultants who should receive new excellence awards. It said that payments should be non-consolidated. The Department of Health told us that the majority of costs of the scheme at both national and local level were for ongoing payments to award holders and pay protection. It said that in 2010-11, just over 95 per cent of the budget was locked up in awards which had been made up to 2009 and, as a result, the monies available for national awards were restricted to around £10 million. At national level, it reported the NHS provision was around £204 million in 2010-11 and it was assumed that the provision was unlikely to increase much in cash terms in 2011-12 and beyond. It said that the scope for making new awards would be heavily influenced by the number of retirements of existing award holders, which it estimated to be about 2.5 per cent of existing award holders each year.
- 6.41 The Scottish Government Health Department (SGHD) told us that, in response to the current economic climate and in an effort to reduce public spending, the Minister had decided that there would be no net increase in the overall numbers of Distinction Award holders available in the 2010 round. The only new awards available were those recycled from consultants who had left the NHS. It said that this had realised a saving of around £2 million. Before the publication of the Scottish Government's draft Budget, Nicola Sturgeon, the Cabinet Secretary for Health and Wellbeing, announced on 16 November 2010 her intention to put a further and more extensive freeze on Distinction Awards paid to consultants. For 2011-12, the value of awards would be frozen, and in addition there would be no new awards made, not even from those freed up by consultants leaving the NHS. The SGHD said this effectively halted the scheme pending the outcome of our review and would save an additional £2 million in 2011-12. It told us that over 12 per cent of Scottish consultants currently received national awards, and that it was aware that over 53 per cent of consultants aged 65 and over who retired in 2010 did so with a Distinction Award. The SGHD said this could lead to the perception that Distinction Awards were a reward for long service rather than an acknowledgement of outstanding performance. The SGHD told us that the budget for Distinction Awards was £28 million in 2010-11. It said that a future scheme should reward excellence or special achievement with one-off awards which were not consolidated and should not regularise recurrent

awards. Nicola Sturgeon subsequently wrote to the parties to confirm that in relation to Distinction Awards, there would be no increase in the value of awards, no new awards, and no progression through the award scheme in 2011-12.

- 6.42 The Management Steering Group of Scottish Employers said that the current scheme was financially unaffordable in the context of current and future financial difficulties faced by the NHS.
- 6.43 Commenting on the freeze on the scheme in Scotland, the British Medical Association said it was dismayed, particularly as it said that Ministers had publicly committed to maintaining a United Kingdom position on award schemes until our review was complete.
- 6.44 ACCEA told us that it might not be necessary to keep identical financial values of the awards to provide the appropriate recognition and incentives, but that it would be important to provide some sort of incentive structure.
- 6.45 The submissions from the Academy of Medical Sciences, British Heart Foundation, Cancer Research UK and the Wellcome Trust, and the Medical Schools Council recorded their concern with the Scottish Government's decision to freeze the Distinction Award scheme for 2011-12, suggesting that it could deter a significant number of aspiring research-active clinicians from pursuing their career in the United Kingdom. The Royal College of Surgeons of Edinburgh also considered that the Scottish Government's decision to suspend the award system was potentially extremely damaging for recruitment to Scotland, and the Clinical Genetics Society recorded its disappointment with the decision to make no new awards in Scotland.
- 6.46 The DHSSPSNI said that it currently allocated £5.8 million to higher awards, but that it had not been possible to increase the budget in the last few years. It told us that the number of higher awards made in recent years was dependent on the number of consultants retiring or leaving the system. It said that, for the 2010-11 awards round, it had taken the decision to make no new awards at local or regional level. However, we later learned that the DHSSPSNI had launched a consultation on whether or not to hold a Clinical Excellence Award round for 2010-11. The DHSSPSNI said that, in Northern Ireland, a consultant needed to have achieved four Clinical Excellence Awards (or Discretionary Points) to become eligible for a higher award. However, it told us that this meant that, if successful, a consultant could receive a rise of between £11,828 and £35,484, and it said that the number and monetary value of awards needed to be considered to ensure that incentives were provided and that awards were commensurate with the level of excellence attained. It thought that structures should be examined to reflect greater emphasis on local excellence with fewer higher awards. It also asked us to consider whether awards should be made on a one-off basis rather than subject to review, and should not be consolidated.
- 6.47 Commenting on the potential threat to the Clinical Excellence Awards for 2010-11, the British Medical Association said this was leading to a severe demoralising effect on Northern Ireland consultants, and was leading many – particularly newly appointed consultants – to question the value of doing anything beyond their contractual requirements. The Royal College of Radiologists recorded its disappointment that no new Clinical Excellence Awards would be made in the 2010-11 round in Northern Ireland, noting the disparity in the number of radiologists with an award in Northern Ireland compared with the rest of the United Kingdom, and said it was concerned that the gap would grow even larger. The Clinical Genetics Society also noted its disappointment with the proposal to freeze the award scheme in Northern Ireland. NICEAC said that there should be no financial incentive for consultants to choose to work in one part of the country rather than another, stressing the need for equity across the United Kingdom.

- 6.48 The Medical Women's Federation said that, if funding was short, it would be better to keep the total number of awards but reduce the monetary value of each. The North East Sub-Committee of ACCEA also proposed a reduction in the value of awards rather than their number.
- 6.49 The Renal Association put forward a specific proposal for the funding of awards: that there should be three tiers of award at 25 per cent, 50 per cent and 75 per cent of the prevailing ten-year consultant salary, at a minimum of 7, 14 and 21 years of service as a consultant.
- 6.50 Some individuals supported a reduction in the number of national awards: one commented on the huge difference between those scoring at the top and bottom of each award and suggested a halving of the bronze award numbers, which they said would increase competition; another noted the falling calibre of bronze applicants over the last two years; one commented on the "sheer number" of awards; one suggested abolishing national awards and reallocating the funds to a more generous career progression reward scheme; and another commented that national awards should be for one year only, decided by the NHS Commissioning Board and should go to a maximum of 0.5 per cent of doctors. However, one individual wrote opposing the reduction in the number of awards saying it was important to reward people for excellence, and another recorded their disappointment at the decision to reduce the number of awards in 2010 ahead of this review. The Academy of Medical Royal Colleges noted that 11 per cent of consultants received national awards and said that this proportion of senior doctors recognised for high quality contributions to the wider health system seemed neither unreasonable nor unexpected. Similarly, the Faculty of Public Health said that the 11 per cent of high-performing doctors receiving national awards was, in its view, a proportionate number. The difference in the value of B awards compared to bronze awards was also drawn to our attention by an individual, suggesting that the historical underfunding of B awards should be corrected.
- 6.51 *As with any future local schemes, we believe the detail of any future national schemes should be determined through negotiation. We have set out in Chapter 10 an example of what we envisage for a national scheme: four levels of award, of £10,000 per annum, £20,000 per annum, £30,000 per annum and £40,000 per annum, to be awarded to 4 per cent, 3 per cent, 2 per cent and 1 per cent of consultants, respectively. The new national schemes would operate in parallel with the new local schemes, so consultants would be eligible to receive payments under both schemes simultaneously. We set out our views earlier in this chapter that a national award should be held for a period of up to an absolute maximum of five years. We believe it should be for the parties to discuss the criteria necessary for determining both the level of award and its duration, but as a general guideline, we would expect the impact of the achievements being rewarded to relate to the level of award, and the sustainability of the achievements being rewarded to relate to the duration of the award. Ultimately, it should be the role of the awarding body to determine the duration of an award using the agreed criteria. We would like to see more flexibility in the duration of national awards so that the full range of up to five years is used. We believe that a maximum of 10 per cent of all consultants should be in receipt of a national award at any point in time. We estimate that such a scheme would cost approximately £91.2 million in England. Our suggestion on the levels of award and percentages of consultants who might receive them is not intended to be binding on the parties, but we consider the arrangement we describe in Chapter 10 to be both appropriate and affordable.*

Retire and return

- 6.52 The Department of Health also told us about another issue it wished to address. It said that national Clinical Excellence Awards ceased on retirement, but that holders of Distinction Awards had historical scope, following retirement, to apply to ACCEA to

reinstate their award if they returned to work in the NHS. The Department said that there was an inherent risk that these consultants were performing a role that was less onerous and beneficial to the NHS than that for which they originally received their award. It told us that while in receipt of the award, 'retire and return' consultants received the benefits of their original award in their pensions plus the cash value of the reinstated award. The Department of Health said it was proposing to discontinue the practice whereby Distinction Award holders could apply for reinstatement of their award if they returned after retirement, and that in the meantime, it was asking ACCEA to only grant a successful review where it was fully justified and defensible. The Chief Medical Officer for the Department of Health subsequently wrote to us in March 2011 to confirm that the Department proposed to consult key stakeholders (including NHS Employers and the British Medical Association) about removing the 'retire and return' provision.

- 6.53 ACCEA told us that, at present, 1.4 per cent of its award budget was spent on awards being paid to consultants who had retired. It said it would support steps being taken to remove this anomaly between the Distinction and Clinical Excellence Award schemes, and that it favoured the restriction of the reinstatement of Distinction Awards after returning to work following retirement.
- 6.54 NHS Employers told us that they did not favour awards automatically going beyond retirement, but that awards should be related to the application of consistent rules related to the contribution of the individual, where it could be fully justified and defended. They said that there were possibly age discrimination reasons that allowed the retire and return provision to exist.
- 6.55 In its evidence, the British Medical Association acknowledged that some aspects of the scheme in England were controversial and agreed it was sensible to keep the scheme under regular review: it drew particular attention to the retire and return provision for holders of Distinction Awards, but noted that the money used for payment of such awards would not then be available for reinvestment for new awards. In supplementary evidence, the British Medical Association said it supported the view that once Distinction Award holders had retired and were in receipt of a pension that partly built on the award, they should no longer be able to claim an award if they returned to work. However, it commented that it would be important for employers to consider other ways to incentivise returnees.
- 6.56 *As with pay protection, it is not clear to us whether the retire and return provision for holders of Distinction Awards (and perhaps Discretionary Points) would fall within the scope of accrued rights for which we are required under our terms of reference for this review to respect. This is properly an issue for the parties to determine. Nevertheless, we wish to place on record our view that, subject to accrued rights, we believe that under any scheme, consultants who retire and return to work should not retain their national awards, although we believe that they should be eligible to apply for a new national award in the same pool as new applicants.*

United Kingdom-wide framework of common principles and governance for a national award scheme

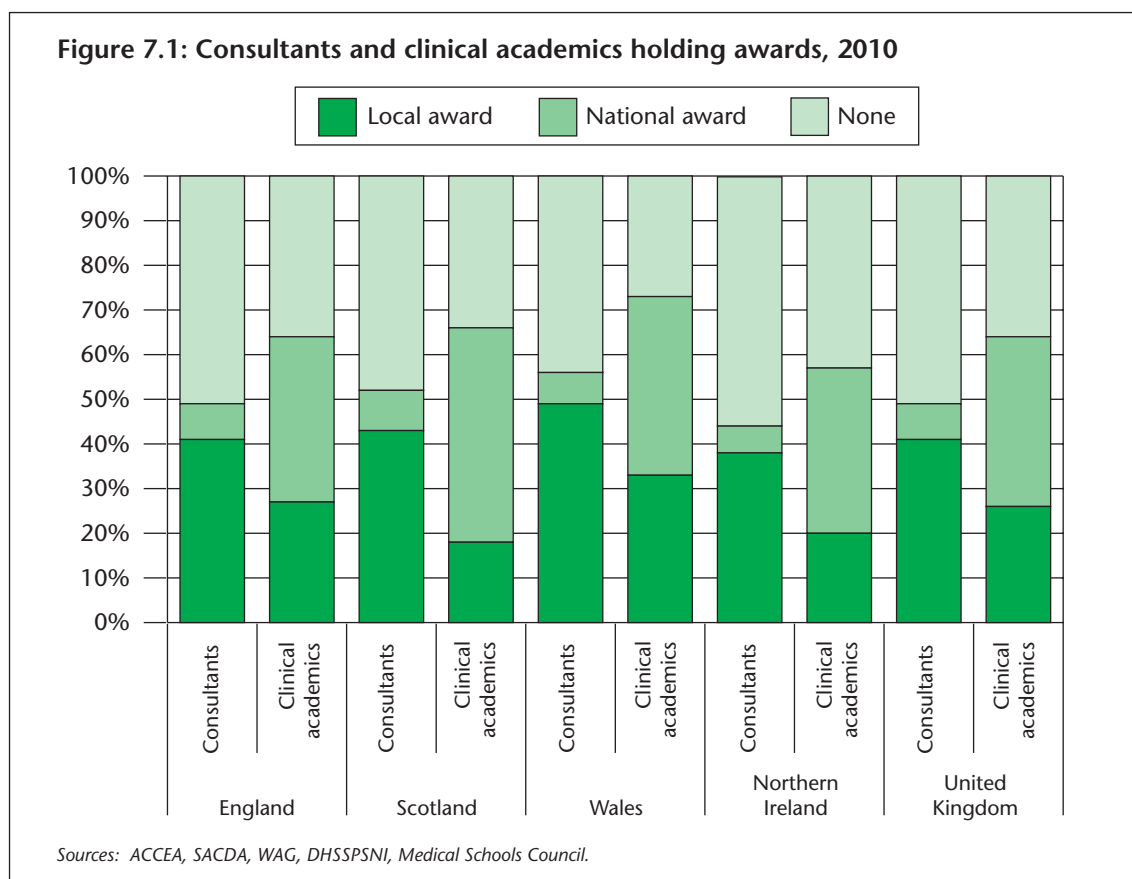
- 6.57 *Our detailed views on pension issues are set out in Chapter 8. With the changes we are recommending for the award schemes, to make them non-consolidated and non-recurrent, we think it is no longer appropriate for awards to be pensionable.*

Recommendation 5: For national award schemes, we recommend that such schemes should operate within a United Kingdom-wide framework of common principles and governance and should include the following:

- awards should recognise those consultants with the greatest sustained levels of performance and commitment to the NHS and whose achievements are of national or international significance;
- the system should be transparent, fair and equitable;
- awards should be made only for work that is done over and above job plans;
- awards should not reward activity already remunerated elsewhere, for example through additional Programmed Activities or Supporting Professional Activities, unless the outcomes are significantly above expectations;
- under the new schemes, local and national awards may be held simultaneously;
- all successful national awards should require 'sign-off' by the employing organisation Chief Executive on an annual basis;
- application for an award should be by self-nomination;
- the cost of national awards should continue to be met centrally;
- awards should be non-consolidated and non-pensionable;
- awards should be held for a period of up to an absolute maximum of five years, the length of which should be determined by the awarding body at the time of granting the award and should be linked to the sustainability of the achievements;
- the level of the national award should be linked to the impact of the achievements;
- consultants should be able to apply for a new award at any time;
- subject to accrued rights, there should be no pay protection;
- existing awards that remain subject to review should not include any grace period; and
- subject to accrued rights, consultants who retire and return to work should not retain any national awards, although they should be eligible to apply for a new national award in the same pool as new applicants.

CHAPTER 7 – CLINICAL ACADEMICS

- 7.1 Clinical academics are doctors or dentists who are employed by Higher Education Institutions, or other organisations, in a research and/or teaching capacity and who also provide services for NHS patients as part of honorary NHS contracts. The group is comprised of consultant clinical academics and senior academic general medical practitioners. There were 2,821 clinical academics with an academic grade of professor, reader or senior lecturer¹ in the United Kingdom in 2010, approximately 5.8 per cent of the remit group for our review.
- 7.2 The Medical Schools Council conducts an annual survey of the staffing levels of clinical academics,² which, amongst other things, collects information on the awards held by clinical academics.
- 7.3 Nearly two-thirds (64 per cent) of clinical academics in each country held an award in 2010, a higher proportion than NHS consultants, with approximately 26 per cent holding a local award, and 38 per cent a national award, a very different balance to NHS consultants (Figure 7.1).

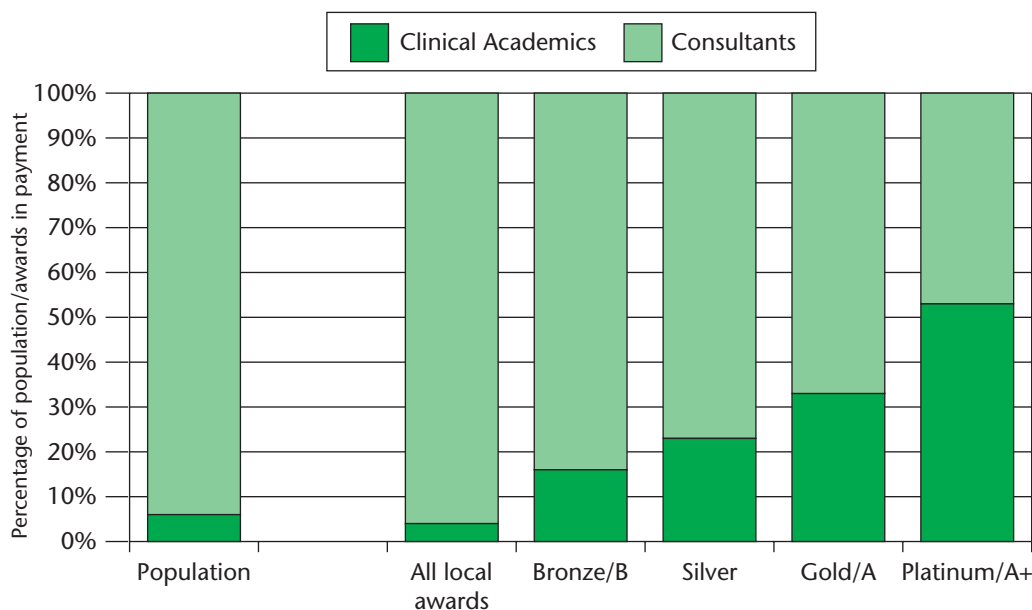


- 7.4 Clinical academics therefore hold a disproportionately high proportion of national awards compared with consultants, with the share of national awards held by clinical academics increasing with the level of award, including over half of the highest awards (platinum Clinical Excellence Awards and A+ Distinction Awards), as shown in Figure 7.2 below.

¹ Guidance from NHS Employers suggests that "experience that is equivalent to consultant level is normally, but not exclusively, senior lecturer, reader or professorial experience". See: *Consultant clinical academic substantive contract: suggested clauses (England)*. Version 5. NHS Employers, March 2008: 2. Available from: http://www.nhsemployers.org/SiteCollectionDocuments/Substantive_clauses_version_5_010308_aw.pdf

² Medical Schools Council. *Staffing levels of medical clinical academics in UK medical schools as at 31 July 2010*. Available from: <http://www.medschools.ac.uk/AboutUs/Projects/Documents/Staffing%20Levels%20of%20Medical%20Clinical%20Academics%20in%20UK%20Medical%20Schools%20May%202011.pdf>

Figure 7.2: Share of awards held by clinical academics, United Kingdom, 2010



Sources: NHS Information Centre, ACCEA, SACDA, WAG, DHSSPSNI, Medical Schools Council.

- 7.5 Many of the respondents to this review were keen to stress that any revised consultant incentive schemes had to be fit for purpose for rewarding clinical academics and researchers. The Department of Health said that if there were no additional national payments, the quality of research and innovation in the NHS could deteriorate if clinical academics considered that they were not being properly rewarded. The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) commented that it was right that consultants who made major contributions to teaching, training or research should have the incentive of an award system.
- 7.6 The Advisory Committee on Clinical Excellence Awards (ACCEA) told us that the inclusion of academic general medical practitioners in the Clinical Excellence Award scheme from 2003 was a response to the perceived differences in remuneration available to full-time general medical practitioners and academics. ACCEA said it was aware that a number of universities had underwritten the pay of academic general medical practitioners to make up their salaries to levels comparable to those of awards, pending their success in obtaining national awards. It told us that the continuation of some mechanism to enable general medical practitioners to take up academic roles without financial disadvantage seemed important. ACCEA also said that questions had been raised with it about the comparative pay of clinical academics and NHS consultants. It reported that monitoring data from the Council of Medical Schools suggested that clinical academics did relatively well in the national Clinical Excellence Award scheme; ACCEA said it had been suggested that awards were important to offset the reduced opportunities of clinical academics to supplement their NHS remuneration with other earnings, although it had no data to confirm such a view.
- 7.7 ACCEA said that the main comparative issue for clinical academics seemed to be with overseas competitors, commenting that it understood that remuneration levels could be significantly higher in other countries. It said that the availability of Clinical Excellence Awards bridged the gap in salaries to some extent. As with academic general medical practitioners, ACCEA told us that it was aware that some academic institutions had on occasion paid remuneration levels equivalent to national Clinical Excellence Awards in order to recruit doctors and had underwritten this amount pending successful applications for awards.

- 7.8 In reply to a question about the responsibility for the pay of clinical academics, NHS Employers told us that universities paid for university work, and the NHS paid for NHS work. Where a clinical academic worked in both university and NHS contexts, it was typical to do this via recharge arrangements, so that the doctor had one official employer but the funding came from more than one source. They thought that the payment of local Clinical Excellence Awards was typically split proportionately between the employing trusts and that national Clinical Excellence Awards were met centrally by ACCEA.
- 7.9 The DHSSPSNI told us that, unlike in England, clinical academic general medical practitioners were not eligible to apply for Clinical Excellence Awards in Northern Ireland.
- 7.10 The Academy of Medical Royal Colleges said that it was essential to maintain and improve recruitment into academic medicine. It told us that clinical academics were discouraged from private practice, as it distracted from and competed with time for research and teaching. It said that awards provided an incentive for talented trainees to choose academic careers, without which the salary differential from private practice opportunities would further deter recruitment to academic areas. The Academy told us that there was a particular problem with recruitment into general practice: only 1 in 225 general practitioners in the United Kingdom were clinical academics, compared to 1 in 16 of consultants in all hospital specialties, and it said that the number of academic general practice training posts was insufficient to sustain existing capacity. It said that full-time academic general practitioners earned about £30,000 less than full-time service colleagues, and that if Clinical Excellence Awards were withdrawn, it would cause recruitment problems. It stressed the importance of an academic primary care evidence base to underpin commissioning decisions. The Academy referred to the potential for earnings overseas, and said that it was important that the United Kingdom health system recognised the potential for the loss of national expertise and was seen to acknowledge and address the issue in practical terms: it considered that Clinical Excellence Awards addressed this very issue. It said that the danger of losing high performers was the greatest in academic, educational and research posts as it was in those fields that there was the greatest movement between countries. The Academy told us that it believed that any serious erosion of the availability of national awards would risk triggering the loss of national medical expertise overseas. The Academy also noted the importance of local Clinical Excellence Awards and stressed the importance of recognising excellence in research, education and training.
- 7.11 A joint submission from the Academy of Medical Sciences, the British Heart Foundation, Cancer Research UK and the Wellcome Trust also stressed the importance of Clinical Excellence Awards, saying that removal of the awards would undermine a major incentive for doctors to engage in medical research and could threaten the United Kingdom's translational science agenda, and would lead to a reduction in the number of clinical academics. It said that the number of applicants for advertised administrative posts for postgraduate medical education and training had fallen substantially, and it was not uncommon to have to re-advertise posts with some remaining vacant for several months. The submission reported that this was because the current funding for postgraduate medical education did not recognise the full cost base for its delivery and oversight.
- 7.12 The Association of United Kingdom University Hospitals said that it was important to recognise the role that clinical academics held in relation to the advancement of medical research. It told us that there were powerful disincentives to embarking upon a clinical academic career and Clinical Excellence Awards had been a useful counterbalance to such disincentives in providing some compensation for eschewing the greater pecuniary rewards that would have been available to many clinical academics had they entered other branches of the profession. It said it was important to recognise that the United Kingdom was competing for the highest achieving clinical academics and it was

important to ensure that the overall reward package was commensurate with those of other academic health science institutions.

7.13 The British Medical Association said that clinical academics straddled and united the worlds of higher education and healthcare, and were a valuable resource to both sectors and to the United Kingdom as a whole. It believed that withdrawing clinical academics from the Clinical Excellence Award scheme would seriously undermine their position and damage the ongoing efforts to encourage joint working between the universities and NHS employers. The British Medical Association said that the core functions of clinical academics – teaching and research – had been at the heart of the policy objectives rewarded by the schemes since their inception, and that it was clear that access to the scheme helped to make academia attractive to doctors. The British Medical Association commented that it knew from its own research³ that there was a pay gap between NHS doctors and those working in academia, and that clinical academic trainees were aware of the pay gap and that it was the cause of some resentment. The British Medical Association said that having access to the award schemes had given clinical academic trainees some assurance that the imbalance would be addressed.

7.14 We received many other comments in support of clinical academics remaining eligible for national awards:

- the British Society of Periodontology said that incentivising career pathways was essential for the success of clinical academia;
- the British Society for Rheumatology commented that rewarding academics who had made a national or international impact with their research would encourage their activity and medical research in general;
- the British Thoracic Society said that recognising the role clinical academics played in terms of undertaking research to advance clinical care in the NHS represented an important feature of the Clinical Excellence Award scheme and helped drive the agenda to focus research on improving clinical outcomes and identifying new drugs;
- the Committee of Postgraduate Dental Deans and Directors told us that if the Clinical Excellence Award scheme was not retained, there was a real risk that the ability to recruit into academic posts would worsen;
- the Conference of Postgraduate Medical Deans of the United Kingdom warned that without Clinical Excellence Awards, it would threaten any new generation of medical educationalists and leaders;
- the Dental Schools Council described the significant contribution that clinical academic dentists made to the NHS;
- the Faculty of Dental Surgery said that at a standard salary, the academic salary did not appeal financially to many;
- the Faculty of Occupational Medicine told us that a reduction in the value of Clinical Excellence Awards might make doctors less inclined to follow academic careers;

³ Sara Connolly and Anita Holdcroft. *The pay gap for women in medicine and academic medicine: an analysis of the WAM database*. British Medical Association, 2009. Available from: <http://www.medicalwomensfederation.org.uk/files/pay%20gap%20report.pdf>

- Guy's and St Thomas' NHS Foundation Trust noted that Clinical Excellence Awards were a fundamental part of the current reward package for clinical academics and stressed the important role they played in relation to the advancement of medical research;
- the Medical Research Council said the Clinical Excellence Award scheme was a cornerstone of the ability of the United Kingdom to retain the top clinical academic innovators;
- the Medical Schools Council warned of a brain drain of academics if Clinical Excellence Awards were withdrawn;
- the Medical Women's Federation said that those working in clinical academic medicine and research generally forewent earnings to undertake such work, and it was important to ensure that bright, able individuals were retained and were not disadvantaged by taking such a career path;
- the Renal Association noted the importance of Clinical Excellence Awards in addressing the earnings shortfall compared to colleagues who had access to private practice;
- the Royal College of Anaesthetists said that it had witnessed an almost terminal decline in clinical academia over the past ten years, and that without Clinical Excellence Awards, it was likely that it would have been fatal;
- the Royal College of General Practitioners told us that without some sort of financial recognition, very few general practitioners would be prepared to move to academic work, as the financial rewards without Clinical Excellence Awards were so much lower than for clinical practice;
- the Society for Academic Primary Care warned of the potential risks to recruitment and retention if awards were withdrawn or scaled back;
- the Society for Endocrinology said that Clinical Excellence Awards provided an important incentive, and drew our attention to the salaries available to clinical academics in the United States of America;
- St George's, University of London also referred to the importance of Clinical Excellence Awards in addressing the differential in terms of potential earnings from private practice;
- the Universities and Colleges Employers Association noted the significant contribution made by clinical academics, often in leadership roles, at national and regional level. It said that salaries on a global scale were high and would only remain competitive with the inclusion of Clinical Excellence Awards, and that the loss of awards would make it harder to attract career clinical academics;
- Universities UK said that Clinical Excellence Awards provided an incentive for younger clinical academics to sustain their academic careers despite the financial disincentives that the longer academic training entailed; and
- the University of Oxford commented that it was not possible to recruit the highest quality clinical academics from North America or Europe without having the ability to offer £130,000 – £160,000, which it noted was above the basic salary scales.

7.15 Some parties suggested amending the current schemes:

- the Renal Association said that several academic nephrologists had argued that the requirement to score highly in all five domains was inequitable, effectively discriminating against those whose work was primarily academic;
- the Royal College of Physicians of London commented that academics should be carefully considered by the scheme, regardless of the number of clinical sessions they undertook;
- the Society for Academic Primary Care said that academic general practitioners in Northern Ireland should, like the rest of the United Kingdom, have access to Clinical Excellence Awards;
- the University of Leicester told us that it was important that the role of clinical academics was not overlooked by placing too much emphasis on management and service delivery; and
- the West Midlands committee of ACCEA said that the employer's part of the citation form needed to be fuller, and that the balance of academics' clinical and non-clinical work and how it was assessed needed to be reviewed.

7.16 Some of the comments related to the way the schemes currently operated:

- the Royal College of Physicians of Edinburgh told us the scheme criteria were weighted to academia;
- the British Society of Paediatric Gastroenterology, Hepatology and Nutrition said that consideration should be given to the balance of scoring between rewarding clinical academics with the time in a job plan for research and training compared to NHS clinicians;
- the Conference of Postgraduate Medical Deans of the United Kingdom considered that the present Clinical Excellence Award system favoured those in clinical and related research and those fulfilling extended management roles, at the expense of those in education and training;
- the Association for Cancer Surgery said that many academics were contracted and paid to teach and perform research, and that credit should only be given for extra activity in research if there was no detriment to the agreed clinical activity;
- the Clinical Genetics Society thought that concerns about the disproportionate number of clinical academics rewarded by Clinical Excellence Awards had been addressed in recent years; and
- some responses from individuals, suggesting: that the schemes favoured research work and academics; that medical academics should be left out of the scheme; that a special case could be made for academic general medical practitioners to enable the gap between the average general medical practitioner's income and an academic salary to be narrowed; and that while there was a principle that the pay of clinical academics should be equivalent to that of NHS clinicians, this approach did create substantial inequities in comparison to non-clinical academics undertaking equivalent jobs.

7.17 *As clinical academics are not part of our usual remit group, we are not normally responsible for making recommendations on any element of their remuneration, although clinical academics are affected by the recommendations in our annual reports on the consultant pay*

scales and the various award schemes to which they have access alongside NHS consultants. For NHS consultants, we are responsible under our standing terms of reference⁴ for making pay recommendations that are sufficient to recruit, retain and motivate sufficient numbers of staff, that take account of: regional/local variations in labour markets and their effects on the recruitment and retention of staff; the funds available to the government; the government's inflation target; and the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

- 7.18 *Clinical academics' salaries are paid by the universities, based on parity with the NHS, a view that we have supported for a number of years in our annual reports, and thus linked to the NHS consultants' pay scale. DDRB recommendations on pay uplifts do not apply to clinical academics; it is the Clinical Academic Staff Sub-Committee of the Joint Negotiation Committee for Higher Education Staff that makes recommendations based on the government's implementation of our recommendations. However, under the terms of reference⁵ for this review, we are required to make recommendations covering NHS consultants, including clinical academics.*
- 7.19 *Our recommendations on the compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants in this review are based on the evidence and our knowledge of NHS consultants, and take into account all aspects of our standing terms of reference. We received some anecdotal evidence that the number of clinical academics had declined prior to the introduction of Clinical Excellence Awards, but that since then, numbers of clinical academics had stabilised. While some of the parties have written to suggest that recruitment has become more difficult, we do not have a clear indication as to the required number of clinical academics necessary for the United Kingdom to enable us to make an informed judgement as to the appropriateness of the current levels of remuneration. That is, we believe, for their employing organisations to determine, taking account of the wider circumstances surrounding clinical academics.*
- 7.20 *Having said that, we believe that in principle, clinical academics should have access to any new award schemes that are introduced for NHS consultants. We recognise that clinical academics are highly valued and are carrying out important work for the NHS, and believe that they should therefore be eligible to receive the same rewards that NHS consultants are able to access for their contributions to the NHS. We note that clinical academics are a highly mobile group, and we consider that their reward package should be such that the United Kingdom remains one of the leading countries in the world for medical research.*
- 7.21 *Our description of how national award schemes might operate in the future (in Chapter 6) proposes that applications are made for a national award, and it will be the responsibility of the awarding bodies to rank applications and make awards of appropriate duration and size. Clinical academics, as with NHS consultants, will therefore be eligible to receive all levels of national award without a requirement to progress through the different levels of award. The key consideration will be an assessment of an individual's contribution to the wider NHS. Clinical academics will also be eligible for local awards under the new scheme we describe in Chapter 5: Figure 7.2 shows that clinical academics hold a small proportion of local awards, so our recommendation to reduce the value of national awards, to reflect the fact that local and national awards can be held simultaneously, may affect the total remuneration received by some clinical academics via the awards. It will therefore be important for employing organisations to ensure that clinical academics are properly considered within local schemes, so that their local contribution is adequately rewarded alongside any national contribution.*
- 7.22 *We note that Scotland intended making clinical academic general medical practitioners eligible for its proposed new system of Scottish Consultants' Clinical Leadership and Excellence*

⁴ The DDRB standing terms of reference are on page i of this report.

⁵ The terms of reference for the review are given in Appendix A.

Awards, but that in Northern Ireland, clinical academic general medical practitioners are not eligible for Clinical Excellence Awards. We ask Northern Ireland to consider whether or not this position continues to be appropriate, particularly if there are any recruitment or retention issues for this group.

Recommendation 6: We recommend that clinical academics holding honorary NHS contracts continue to have access to any future local and national award schemes alongside NHS consultants.

7.23 *In its evidence to us, ACCEA commented that it was aware that some employers were paying clinical academics at remuneration levels equivalent to national Clinical Excellence Awards in order to recruit doctors and had underwritten this amount pending successful applications for awards. We explored this issue during oral evidence, as it raised a possible concern: it would appear to introduce the potential for some level of bias in the advice that employing organisations make to the awarding bodies for the various awards, particularly for national awards where the funding of awards moves from the employing organisation to a central fund. None of the parties indicated to us that they thought that the award process was being undermined by this issue. Despite such assurances, we remain uneasy that awards may be being used to compensate for an inadequate pay system: we believe that universities should pay an appropriate level of remuneration necessary to recruit and retain sufficient numbers of suitably qualified and experienced clinical academics. The award schemes should then provide supplements to basic pay for those making a substantial contribution to the NHS either at a local or national level.*

CHAPTER 8 –PENSION ISSUES

8.1 This chapter looks at the various pension issues arising from our review. We are required by the terms of reference¹ that this review be fully linked to other activity on public sector pay, including the review of public service pensions by Lord Hutton’s Independent Public Service Pensions Commission.

The current pension situation

8.2 At present, all Clinical Excellence Awards, Distinction Awards, Discretionary Points and Commitment Awards are consolidated into basic pay and are pensionable. Most consultants will be in the 1995 section of the NHS Pension Scheme, giving a final salary pension, with an accrual rate of 1/80ths and a tax-free lump-sum of three times annual pension, with a retirement age of 60. A small, but increasing, proportion will be in the 2008 NHS Pension Scheme, also a final salary scheme, but with an accrual rate of 1/60ths and a retirement age of 65. Employee contribution levels are 7.5 per cent for those with full-time equivalent earnings over £69,932, and 8.5 per cent for those with full-time equivalent earnings over £110,274.

8.3 According to the consultant contract,² the following elements of pay are pensionable:

- the basic salary (up to ten Programmed Activities), including pay thresholds;
- enhancements to basic salary by way of any Discretionary Points, Distinction Awards or Clinical Excellence Awards;
- any on-call availability supplement;
- any London weighting allowance; and
- fees for domiciliary visits not undertaken during Programmed Activities.

8.4 The following are not pensionable:

- travelling, subsistence, and other expenses paid as a consequence of work for the employing organisation or the wider NHS;
- any recruitment or retention premium;
- any payments for additional Programmed Activities; and
- any payments for work undertaken for Local Authorities, subject to local agreements to the contrary.

8.5 The contract states that:

“If a Distinction Award or Clinical Excellence Award is removed or downgraded, the consultant will normally continue to be paid the value of the award he or she received at the time this decision was made. This will be taken into account in the calculation of the consultant’s pension in the normal way... In exceptional circumstances, a consultant may lose the value of the award as well as the award itself. This may affect the value of the consultant’s pension depending on the date on which this deduction was made”.

¹ The terms of reference for the review are at Appendix A.

² *Terms and conditions – consultants (England) 2003*: Schedule 17. Available from: http://www.nhsemployers.org/SiteCollectionDocuments/Consultant_Contract_V8_Revised_Terms_and_Conditions_220808_aw.pdf

The Independent Public Service Pensions Commission

- 8.6 The environment for public sector pensions is changing, as the debate on widespread reform gathers pace. The impact on pensions for our remit group as well as others in the public sector is likely to be significant. Lord Hutton's *Independent Public Service Pensions Commission* was commissioned by the Chancellor in June 2010 to report on public sector pensions in time for the March 2011 budget. The Commission published an interim report³ in October 2010 highlighting its progress in considering long-term structural reform options and savings within the current spending review period. It found that the current public sector pensions structure had been unable to respond flexibly to workforce and demographic changes in the past few decades. In his response to the Commission's interim report, the Chancellor announced in the *Spending Review 2010*⁴ the United Kingdom government's intention to implement progressive changes from 2012 to the level of employee pension contributions, equivalent to 3 percentage points on average, leading to substantial savings to the Exchequer by 2014-15.
- 8.7 In his final report in March 2011,⁵ Lord Hutton's report made a number of recommendations for public service pensions, the most important of which for our remit group were:
- a move from final salary to career average pension schemes; and
 - an alignment of the normal pension age under public sector pension schemes with the state pension age.
- 8.8 The government accepted Lord Hutton's recommendations in its budget in March 2011 as a basis for consultation with public sector workers, trades unions and others. It undertook to set out proposals in the autumn which were affordable, sustainable and fair to both the public sector workforce and the taxpayer.⁶
- 8.9 *We note that whilst the increased contribution rates already announced are planned by government to take effect fairly soon, in 2012, other recommendations referred to above, should they be implemented, are likely to have a phased impact over a number of decades. Though we have yet to see the government's detailed proposals for the NHS pension schemes in response to the reports by the Independent Public Service Pensions Commission, we have been informed by the Commission's deliberations in making our own recommendations.*
- 8.10 The fact that awards are pensionable was highlighted as a key benefit to the current pay structure by a number of bodies.⁷ The British Medical Association said that much had been made of the fact that Clinical Excellence Awards, Distinction Awards and Discretionary Points were pensionable whereas typically bonus payments were not. It also said that the pension arrangements for comparable professions were in many cases very different from those of public sector employees.

³ Independent Public Service Pensions Commission. *Interim report*. 7 October 2010. Available from: http://www.hm-treasury.gov.uk/d/hutton_pensionsinterim_071010.pdf

⁴ HM Treasury. *Spending review 2010*. Cm 7942. TSO, October 2010. Available from: http://cdn.hm-treasury.gov.uk/sr2010_completereport.pdf

⁵ Independent Public Service Pensions Commission. *Final report*. 10 March 2011. Available from: http://cdn.hm-treasury.gov.uk/hutton_final_100311.pdf

⁶ HM Treasury. *Budget 2011*. HC 836. TSO, March 2011: para. 1.132. Available from: http://cdn.hm-treasury.gov.uk/2011budget_complete.pdf

⁷ Including: the Association of Anaesthetists of Great Britain and Ireland; the joint submission from the Academy of Medical Sciences, the British Heart Foundation, Cancer Research UK and the Wellcome Trust; the British Society of Periodontology; the Dental Schools Council; the Local Negotiating Committee of Yeovil District Hospital; the Medical Women's Federation; the Royal College of Physicians of Edinburgh; and the University of Oxford. Individual responses also noted the importance of the pensionability of awards: one said that back in 1978, their first contract was for 104 hours a week, of which only 40 hours were pensionable; and another said that they thought the inclusion of awards in pensionable pay was the biggest benefit.

- 8.11 The British Medical Association reminded us of our own comments in our *Thirty-Ninth Report*⁸ when we concluded that:
- “NHS pensions are more generous than private sector comparators and even more rewarding than private sector comparators for new entrants. However, the non-pension aspects of total reward⁹ are potentially significantly higher for most private sector comparators, so overall we are not concerned about the pensions of our remit group”.
- 8.12 The British Medical Association said that the implications of the Hutton report, and the changes to pensions’ tax relief, together with the fact that we had hitherto expressed no concern about the pensionability of Clinical Excellence Awards, meant that there should be no reason for us to recommend any changes to the Clinical Excellence Award, Distinction Award and Discretionary Point schemes for reasons of pensionability. It added that if we were to make any recommendations that did affect pensionability, then this should be recognised by an increase in the value and/or incidence of awards.
- 8.13 The British Medical Association said that it would be possible to continue to pension awards even if we were to conclude that awards should no longer be subject to the same review arrangements. It said this could be achieved by pensioning them separately as variable pay under a career average remuneration arrangement.
- 8.14 The Department of Health said that the pensionability of awards should follow the overall approach taken across the public service pensions schemes following the final Hutton report. In supplementary evidence, the Department went further, suggesting that awards for the future should be non-pensionable.
- 8.15 In its submission, NHS Employers said there was a lot of opposition to Clinical Excellence Awards attracting pension contributions and counting towards final salary in the pension scheme rules. They said that employers believed that awards should not be part of pensionable pay, as it imposed unacceptable costs on employers and on the NHS pensions schemes and scheme members. Being subject to pension contributions imposed a 14 per cent employer contribution cost on the award – over £10,500 of employer contributions per year in addition to the pay costs themselves in the case of a platinum award.
- 8.16 NHS Employers questioned whether it remained acceptable for awards to be pensionable. They said that in terms of equity in the pension scheme itself, for example, gold and platinum awards were on average awarded at age 55 and 56 to doctors with a normal retirement age of 60. Thus for just four or five years’ employee contributions – say £36,000 over five years – a platinum award holding consultant’s pension was increased by around half a million pounds if they lived just 15 years after normal retirement age, with an increase in annual pension far in excess of the average NHS pension in payment. They said that a basic pay pension of about £60,000 per annum could become nearer £95,000 per annum for only four years’ contributions. NHS Employers questioned whether it was appropriate for such a disparate impact on employee pensions to occur. In conclusion, NHS Employers said that awards should stop being part of pensionable pay.
- 8.17 The Scottish Advisory Committee on Distinction Awards (SACDA) said that the consultant reward scheme should be non-consolidated and non-pensionable. It recognised that these suggestions would impact on the current consultant contract and might mean that the contract would need to be renegotiated.

⁸ Review Body on Doctors’ and Dentists’ Remuneration. *Thirty-Ninth Report*. TSO, 2010: para. 1.73. Available from: http://www.ome.uk.com/DDRB_Main_Reports.aspx

⁹ For example, annual bonuses, fixed payments, recognition payments and company cars.

- 8.18 The Scottish Government said that there was no other staff group within NHS Scotland (or, indeed, any staff group that fell under Scottish Ministers' public pay policy) that received consolidated, pensionable payments in addition to basic salaries. It said that while consultants continued to benefit from such generous arrangements, the fairness of the scheme would be called into question.
- 8.19 The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) said that as awards were consolidated for pension purposes, this created additional cost pressures for employers and resulted in higher pensions being paid when consultants retired. DHSSPSNI said its view was that future awards should not be consolidated for pension purposes.
- 8.20 The Ministry of Defence said it was keen to continue the non-pensionability of Clinical Excellence Awards in its own Clinical Excellence Award scheme, to ensure that the awards were properly classed as exceptional 'bonus payments' rather than part of an individual's overall pay package, which was pensionable. It said it would like to see the alignment of the NHS and Ministry of Defence schemes in this area.
- 8.21 In its submission, the Advisory Committee on Clinical Excellence Awards (ACCEA) said that the pensionability of awards seemed anomalous when compared to other bonus schemes, but was less surprising if awards were seen as mainstream salary. ACCEA said it did not believe that pensionability was essential to the scheme's contribution as an incentive for excellence. It said there were arguments in favour of permitting consultants to choose whether or not to invest part of their remuneration in a pension, but it was not clear whether pensionability was important for recruitment. It said that if pensionability was removed, it might encourage some premature retirements and might therefore be important in a retention context. However, ACCEA thought that wider public sector pension and taxation reforms would be a more significant factor.

Other developments in pension provision

- 8.22 *We are conscious that the switch in pensions indexation from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI) from April 2011 will affect the value of future pensions payments. CPI inflation is typically lower than the RPI measure, as a result of its different coverage, in particular the exclusion of housing costs, and different formulae. The CPI inflation rate has been on average 0.7 percentage points lower than the RPI measure in the period since 1989. Consequently, the move to CPI indexation will lower substantially the value of pensions in payment.*
- 8.23 *Furthermore, the changed tax regime, that reduces the annual allowance for tax relieved pension savings to £50,000 from April 2011¹⁰ and the lifetime allowance to £1.5 million from April 2012, will affect the highest earners in our remit group.*

The value of the pension element of awards

- 8.24 *There is no doubt that awards being pensionable under a final salary scheme is of very high value to individuals, and that neither the contributions paid by the individual nor the employer reflect the full current cost of these benefits. Table 8.1 demonstrates that a salary increase of £23,656 in the final year before retirement, say through the award of a bronze Clinical Excellence Award, would lead to a £10,349 increase in annual pension (worth over £186,283 extra by age 75¹¹). Employee pension contributions on this would have been 8.5*

¹⁰With offsets from the previous two tax years. The British Medical Association said, in evidence, that these changes would particularly affect those with relatively high incomes and long service, with serious financial implications for those who received substantial promotion or other pensionable pay increases.

¹¹Taking 15 years of pension at nominal values, and including the lump sum. The valuation of future pensions would normally be discounted, but would also be subject to annual CPI increases.

per cent, i.e. £2,011. Under a career average scheme, the additional value of the bronze award (£23,656) would be averaged over the 35 years of service, so annual pension would only be increased by £296 a year (assuming the same accrual rate of 1/80ths); worth £4,436 extra by age 75, excluding any lump sum

Table 8.1: Impact of awarding a bronze Clinical Excellence Award on pension under final salary scheme

	Consultant A		Consultant B	
Service at age 60	35 years		35 years	
Salary at age 59	£112,274	(top of pay scale plus local CEA 4)	£112,274	(top of pay scale plus local CEA 4)
Salary at age 60	£135,930	(top of pay scale plus bronze national CEA)	£112,274	(top of pay scale plus local CEA 4)
Pension	£59,469	Plus £178,408 lump sum	£49,120	Plus £147,360 lump sum

Recommendations

8.25 *If accepted, the recommendations we have made in Chapters 5 and 6 mean that, in future, awards will be time limited, and not form part of basic salary. We can understand why, at the introduction of the award schemes in 1948, it was felt necessary to make these awards consolidated and pensionable. We recognise that a career average approach may be introduced, but as a point of principle, with the changes we are recommending for the award schemes, we think it is no longer appropriate for the awards to be pensionable. This is consistent with practice across the public and private sectors. Individuals have the option to make additional voluntary contributions from their award to the NHS (or a private) pension scheme.*

Recommendation 7: We recommend that payments made under any new award scheme, at national or local level, should be made on a non-pensionable basis.

8.26 *We also believe that existing awards should become non-pensionable in future. Leaving them pensionable for future service would create a differential between consultants on the current and the new schemes, and act as a disincentive to participate in the new award schemes. Individuals' accrued rights should be protected, however, so that the cash value of an existing award would remain pensionable for past service. A suitable period of notice, to be determined by the parties, should be given before these changes are implemented, so as not to cause undue disruption to those planning to retire soon.*

Recommendation 8: We recommend that existing awards are no longer pensionable for future service, following a suitable transition period, to be determined by the parties.

8.27 *These recommendations will deliver significant savings to the cost of future pensions and we are aware that they will, viewed in isolation, reduce the value of the total reward package to consultants in receipt of the awards. The value of the awards may need to be considered in future in the light of this, and the impact on retention, particularly for those near to retirement age, will need to be monitored closely. We will continue to assess the value of the total reward package relative to comparator groups in our future reports.*

CHAPTER 9 – GOVERNANCE AND OPERATION OF THE AWARD SCHEMES

- 9.1 In this chapter we consider how the award schemes work in practice and make our recommendations for how future schemes could be fair and equitable. Our detailed recommendations relating to local and national awards and to the pensionability of the schemes are given earlier in this report, in Chapters 5, 6 and 8 respectively.
- 9.2 We are required by the terms of reference¹ to provide assurance that any system for the future includes a process which is fair and equitable.

Recipients of awards

- 9.3 We received a substantial amount of evidence addressing perceived bias and unfairness in the schemes. There were criticisms that the schemes variously favoured academics and those carrying out research, the dominance of the system by doctors or consultants holding clinical management contracts or on committees. The Conference of Postgraduate Medical Deans of the United Kingdom believed that the current scheme favoured those in clinical and related research and those filling extended management roles within the NHS (whether directly clinical or not), at the expense of those in education and training. A few respondents commented that the real success in achieving awards lay in the ability to 'sell' oneself or how much influence one had with the members of professional bodies and societies whose recommendations decided how the higher awards were distributed.
- 9.4 Other respondents to the consultation expressed concern that the schemes should cover all specialties and that the number of awards should reflect the specialty. Specifically:
- the Royal College of Radiologists was critical that clinical oncology was not identified as a separate discipline from radiology;
 - the Association of Anaesthetists, the British Pain Society and the Neuroanaesthesia Society of Great Britain and Ireland suggested that anaesthetists received a smaller proportion of awards;
 - the British Society of Rehabilitation Medicine reported that consultants in rehabilitation medicine were under-represented in the awards system;
 - one individual suggested that there was potential resentment amongst consultants working in specialties that received a low proportion of awards; and
 - the Clinical Genetics Society commented that, while in the past there had been concerns that the system rewarded clinical academics disproportionately, this was no longer the case and hard-working clinicians were now able to have their equally-important clinical contribution fully recognised.
- 9.5 With regard to the work carried out that might lead to recognition through an award, several respondents complained that other consultants provided the clinical back up for consultants doing high profile 'award worthy' duties and that the work valued by these schemes took consultants away from the workplace. They argued that better recognition was needed for those providing NHS activity. For example:

¹ The full terms of reference for the review are given in Appendix A.

- the Society for Cardiothoracic Surgery in Great Britain and Ireland said that a common criticism of the scheme was that it rewarded those who did not completely fulfil their clinical commitments at their base trust. It believed that the scheme should genuinely reward output that exceeded a consultant's job plan and that the necessary flexibility for this could be achieved with an annualised job plan;
- a high number of respondents stressed that the work to gain awards was carried out mainly during evenings and weekends, or outside of contracted hours;
- one individual questioned whether awards were being made for work that consultants should be doing anyway; and
- one individual commented that the local schemes produced more losers than winners each year. He said that the apparently uneven allocation of points between trusts had created the appearance that NHS consultants in teaching hospitals were significantly disadvantaged as they were competing against clinical academics.

9.6 Some respondents expressed concern about the amount of private practice undertaken by award holders:

- the British Society of Periodontology argued that the system should be limited to those who were absolutely committed to the NHS and suggested that consultants carrying out private practice on more than half a day a week should be excluded from the scheme; and
- the Clinical Genetics Society made what it considered to be a controversial suggestion that applicants for awards should be asked to state how much private practice they undertook. It believed that awards should not be made for non-NHS work and commented that the awards were appropriately generous for NHS consultants who chose not to do private practice.

9.7 We received many suggestions for our consideration regarding any future scheme:

- a common theme was that the scheme must be fit for purpose for rewarding clinical academics and researchers, although one individual believed that academics should be excluded;
- some wanted the awards to be granted consistently around the United Kingdom;
- the Royal College of Radiologists specifically commented on the disparity in the number of radiologists with an award in Northern Ireland compared with the rest of the United Kingdom and expressed concern that the freeze on new Clinical Excellence Awards in Northern Ireland for the 2010-11 round would widen the gap further;
- the Royal College of Physicians of Edinburgh warned of the potential to introduce a market for doctors across the United Kingdom if any future system of awards was not nationwide; and
- the Faculty of Pharmaceutical Medicine suggested that the referral of patients to clinical trials should be recognised by the scheme.

9.8 *We note the concerns about the eligibility for awards of consultants working in private practice. However, we believe that the opportunity to carry out private work is part of the total reward package for consultants and that the award schemes should continue to apply to all consultants working in the NHS. As the schemes aim to reward those consultants making a*

sustained contribution to the NHS, we would expect the schemes to favour those consultants who are most committed to the NHS.

9.9 *We have addressed many of the concerns about the recipients of awards in the United Kingdom-wide framework of common principles and governance that we have proposed for the new national and local award schemes (see Chapters 5 and 6). Our principles state that awards should only be made for work that is done over and above job plans, and that awards should not reward activity already remunerated elsewhere, for example through additional Programmed Activities or Supporting Professional Activities, unless the outcomes are significantly above expectations. Following the implementation of our recommendations, we expect to see a system that is even more transparent than at present, and fair and equitable to all.*

The operation of the schemes

9.10 We received several comments and suggestions about the various awarding committees:

- one individual said that while the Advisory Committee on Clinical Excellence Awards (ACCEA) regional committees operated in a transparent, robust and fair way, he believed that there was a wide variation in practice, governance arrangements, scoring systems and the delivery of fairness and equality in the local, employer-based award committees;
- the Royal College of Obstetricians and Gynaecologists said that the structure of the awarding body, both nationally and locally, must be representative and inclusive. It suggested that the awarding body should continue to invite evidence-based support from the Royal Colleges, the Department of Health and other national bodies and that lay appointments should be transparent and provide added value;
- the West Midlands sub-committee of ACCEA argued for the increased involvement of lay persons;
- the British Society for Rheumatology suggested the involvement of patients or patient groups and carers, and that decisions should be informed through the use of health outcomes data, where these were available;
- the Scottish Advisory Committee on Distinction Awards (SACDA) noted the need for a national committee. It said that the highest performing consultants were not spread evenly across employers, that it was hard to recognise national and international work locally, but that a national committee could consider comparability of achievement across the country;
- one individual argued that the regional sub-committees should be replaced with trust and Royal College assessments;
- the Medical Women's Federation told us that more female professional members were needed on regional Clinical Excellence Award sub-committees;
- one individual commented on the amount of bitterness that arose because some specialties always fared better. He suggested that national awards should be allocated by specialty to ensure a more even distribution; and
- the Welsh Assembly Government (WAG) believed that the criteria for success should be more closely aligned with the objectives of the employing organisation, particularly in relation to future service modernisation in Wales.

9.11 We note from SACDA that in order to retain a strong local (i.e. Scotland-wide) element to the scheme, Scotland would wish to retain its independence but would operate in line with a United Kingdom-wide agreed scheme. During oral evidence, Nicola Sturgeon, Deputy First Minister and Cabinet Secretary for Health and Wellbeing, reminded us that responsibility for the scheme was devolved to the Scottish Government, that she had the freedom to change the scheme if desired and would consider further reform if necessary, although her preference was for a United Kingdom-wide scheme. The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) and the Northern Ireland Clinical Excellence Awards Committee (NICEAC) were also keen that the new scheme should have the same approach across the whole of the United Kingdom. On the other hand, the WAG saw the review as providing an opportunity for Wales to have its own scheme in preference to the joint national scheme for England and Wales.

9.12 A number of responses were critical of the schemes and we include some of these criticisms here:

- one individual told us that the prevailing system was defective, divisive, archaic and out-dated and that it had no public support;
- another described the system as inherently flawed, corrupt, biased and slanted more towards favouring a select group of consultants carefully nurtured by trust managers;
- the Royal College of Obstetricians and Gynaecologists suggested that the present matrix of scoring and demonstrating evidence should be reconsidered;
- the British Society of Periodontology said that it could be difficult to verify the achievements reported in the citations;
- the West Midlands sub-committee of ACCEA believed that the citation process should be audited; it also suggested that the employer's part of the form should be fuller and the balance of academics' clinical and non-clinical work and how it was assessed should be reviewed;
- the Royal College of Radiologists argued that the administration process and structure of the application forms should be simplified. It said that the current cost and time of administering and applying for the schemes could not be justified, particularly with reviews becoming more rigorous;
- the British Medical Association commented on the need to strengthen all local processes through sound central guidance; and
- NHS Employers were critical of the disconnect with performance, appraisal and job planning. They expressed doubt about whether the links to the objectives of posts, as set through job planning and appraisal systems, could really be seen to be incentivised or rewarded by the current system. They said that fairly or unfairly, the scheme was widely seen as one regulated by and for the medical profession rather than the needs of the service and its patients. Employers said that they would have more confidence in a system where there were stronger links to organisational objectives.

9.13 *We have addressed the need for a closer link to the appraisal system in Chapter 5, and one of our recommended principles for local schemes relates to the need for measurable targets linked to both the objectives of the employing organisations and the personal objectives of individual consultants.*

9.14 *We have taken the criticisms and other comments on the schemes into account when preparing our recommendations. We think that the recommendations we have made, including the United Kingdom-wide framework of common principles and governance under which we believe the schemes should operate, represent a positive way forward for the schemes.*

Principles upon which the new schemes should operate

9.15 *We believe that there should be a United Kingdom-wide framework of common principles and governance for the local award scheme and we have set this out in Chapter 5. However, we believe that many employers need to develop a more rigorous approach to performance management and appraisals. We have set out the United Kingdom-wide framework of common principles and governance for the national award scheme in Chapter 6.*

Transparency

9.16 A high number of respondents said that they considered the current award schemes to be transparent, fair and robust and commented that the schemes were much better than they used to be. For example:

- the Academy of Medical Royal Colleges welcomed the “vast improvement” in the operation and application of the award system, at both local and national level, over recent years;
- the Committee of Postgraduate Dental Deans and Directors noted that the system had been improved and refined year on year, although it said that there was always scope for further improvement;
- the North East sub-committee of ACCEA believed that the increased openness surrounding the national awards helped to build confidence in the system;
- one individual commented that the Clinical Excellence Award system was largely seen within the medical profession as a highly competitive but fair process;
- NHS Employers criticised what they perceived as the lack of transparency in the process; in particular they said that the entry level for regional and national awards in terms of locally-awarded Clinical Excellence Awards was often not clear, and they criticised the lack of clarity in the role of non-employing organisations, such as professional associations and colleges, in the process and the weight given to their views. Nevertheless, they told us during oral evidence that they believed that, although more could still be done, the transparency around national awards had improved, for example, regarding the influence of ACCEA on decisions. They believed that the regional committees needed more power to challenge ACCEA’s decisions;
- the British Cardiovascular Society commented on the lack of clarity used centrally to determine awards and suggested that unsuccessful candidates be given an indication of their ranking relative to the threshold required for an award;
- the Renal Association also said that the scheme failed badly on the provision of feedback to unsuccessful candidates;
- we received individual complaints about the lack of clear criteria for progression from one level to the next, and the need for better proof of achievement;

- the Committee of Postgraduate Dental Deans and Directors observed that there was uncertainty about what appeared to be unwritten rules relating to applications for local and national awards, for example, the number of local awards needed before applying for a national award;
- both the British Pain Society and the Medical Research Council said that more clarity was needed on the role and weight given to citations from supporting bodies;
- during oral evidence, the Universities and Colleges Employers Association suggested that applications should make clear the amount of time spent on private practice; and
- SACDA, also during oral evidence, said that applicants should declare their income from private sources.

9.17 *We believe that transparency, fairness and equity are fundamental principles under which all the award schemes should operate. As the schemes continue to develop, following implementation of our recommendations, we would expect to see further improvements in the transparency of the schemes. For example, we think it is important that the awarding bodies should provide clear feedback to interested parties when their decisions are questioned. We have also recommended in Chapter 5 that employing organisations should publish annual data on the awards made and details of their local award schemes.*

Criteria/domains for awards

9.18 Some respondents, including the British Association of Stroke Physicians, the British Medical Association and the DHSSPSNI, said that they would like the schemes to be harmonised across the United Kingdom and to have commonality. In addition, NICEAC believed that there should be no financial incentive for consultants to choose to work in one part of the United Kingdom rather than another; in its view it was therefore essential that any new system was applied equitably across the United Kingdom. Some respondents, including Leeds Teaching Hospitals NHS Trust, NHS Employers and NICEAC believed that trusts should have more say about who received awards. NHS Employers said that the national awards process placed too low a value on the views of employers and believed that the support of an employer Chief Executive should be mandatory for an award.

9.19 We received a number of very specific comments related to the criteria for gaining an award:

- the Academy of Medical Royal Colleges and the British Medical Association told us that they supported the current criteria for the scheme;
- the British Medical Association told us at oral evidence that it would not wish to see a focus away from clinical work;
- we received individual responses saying that the criteria should be clear, that the terminology needed to be better defined, and the relative roles of meritorious service and distinction should be made clearer;
- the Leeds Teaching Hospitals NHS Trust believed that a firm definition of excellence was required;
- one individual said that clarification was needed as to how clinical governance by individuals was assessed for award purposes;

- the Royal College of Radiologists observed that the award scheme gave a much stronger emphasis to the need for applicants to specify their individual contribution to each domain, but said that it was not always possible to differentiate between individual and team achievement;
- the West Midlands sub-committee of ACCEA and an individual respondent told us that there was a need for more meaningful citations/references from employers and professional bodies;
- some individual respondents believed that the awards should recognise clinical care rather than management, academic or committee work, as this was covered by Supporting Professional Activities, and that better monitoring of the time spent on Supporting Professional Activities was needed; and
- the Medical Women's Federation expressed concern that there may be gender bias in the domains used for scoring applicants.

Concerns and suggestions for improvement

9.20 Suggestions for improvement to the schemes were made by a number of respondents. For example:

- the Renal Association believed that the requirement to score highly in all five domains was inequitable and effectively discriminated against those whose work was mainly academic and had no opportunity for service development or clinical management;
- the Wales Awards Committee said that the domains should be reviewed to ensure that no specialty was disadvantaged in the scheme because of the nature, type and balance of clinical care provided. It also expressed concern about overlaps between the domains where double counting might occur;
- the Society for Cardiothoracic Surgery in Great Britain and Ireland argued the need for a clearer description of criteria that defined high quality care and continuous improvement and that showed a demonstrable improvement in outcomes;
- the Academy of Medical Sciences, British Heart Foundation, Cancer Research UK and the Wellcome Trust, believed that serious consideration should be given to the economic and health impact of research;
- the London North East sub-committee of ACCEA expressed disquiet about how applicants should be scored when their main contribution was to international health care rather than to the NHS;
- the Leeds Teaching Hospital NHS Trust argued for increased management input to the citation process, as the awards should be linked to the work for the clinical management team and the achievement of the trust. It said that the job plan section was weak and did not match the construct of the national contract;
- the Neuroanaesthesia Society of Great Britain and Ireland told us that current scheme criteria may not be able to discriminate excellence in anaesthetic practice due to the different way that anaesthetists worked compared to other specialists;

- the Royal College of Radiologists thought that there needed to be absolute clarity about what was truly national and what was actually an extension of enhanced local and regional awards. It suggested a three-tier process of local, regional and national awards, with only the national awards being administered by a central body, such as ACCEA;
- one individual response told us that the schemes were out-dated and as currently constituted were inconsistent with the theory and evidence of incentive structures; and
- another respondent suggested that if the schemes were to be maintained, they should be developed to encourage directly NHS priorities, including better signals of consultants' NHS clinical activity, outcomes and costs, rather than the vaguely defined 'excellence' which too often rewarded activities related to esteem, which were achieved outside the NHS.

9.21 *We believe that the implementation of our recommendations, in particular the United Kingdom-wide framework of common principles and governance under which local and national awards should operate, will address many of the concerns expressed about the existing award schemes. However, we do not see it as our role to go into depth on the domains, as we believe that it is a matter for the parties to agree. We think that, in the light of the changes that we are recommending for the schemes, the awarding bodies should revisit the domains and their weightings, in particular to distinguish elements of the domains with a local focus from those elements with a national focus, while ensuring that work carried out at a local level for the wider NHS is still recognised. As we have said in Chapter 5, we would also like to see the introduction of objective measures, quantifiable if possible, and a closer link between local awards and the appraisal process.*

Recommendation 9: We recommend that, in the light of the changes that we are recommending for the schemes, the awarding bodies should revisit the domains and their weightings, in particular to distinguish elements of the domains with a local focus from those elements with a national focus, while ensuring that work carried out at a local level for the wider NHS is still recognised.

Recognition of work for the Royal Colleges

- 9.22 The Department of Health proposed that national awards should no longer be given in recognition of work done for the Royal Colleges. It said that instead the Department would pay the Colleges an annual amount with which they could reimburse trusts whose consultants carried out such work.
- 9.23 We received a number of representations disagreeing with this proposal, including from the WAG, which was concerned about funding implications, and the Scottish Government Health Department (SGHD), which viewed the proposals as unwieldy and bureaucratic. However, during oral evidence Nicola Sturgeon, Deputy First Minister and Cabinet Secretary for Health and Wellbeing, told us that she thought it was legitimate to debate whether such work should be recognised through the incentive schemes, noting that the Royal Colleges were self-funded organisations. It was not a major issue for the DHSSPSNI as little work for the Royal Colleges was carried out in Northern Ireland.
- 9.24 The Academy of Medical Royal Colleges reacted strongly against this proposal and told us in supplementary evidence that it considered the Department's rationale to be "illogical" and the effects "invidious". It also noted that that the details were unclear as to how such an arrangement might work. The Academy believed that the Department of Health had combined the two separate issues of the potential need to reimburse trusts

for the time that consultants spent on College work away from the workplace, and the question of whether work undertaken for the Colleges should be eligible for a national award. It pointed out that the roles performed by Colleges to the benefit of the NHS included: training future consultants and general practitioners; ensuring and improving quality of patient care; workforce planning; and advice. It said that these activities were essential to the NHS and if not provided by the Colleges then the NHS would need to pay other providers for these services. The Academy believed that there was no logic in the proposal to exclude all College work from consideration for national awards and said that this would be deeply resented by doctors.

9.25 The Royal College of Obstetricians and Gynaecologists argued that senior clinicians working with the College did so because of benefits to the NHS as a whole and said that standards had improved year on year as a result of such activity, with the key beneficiary being the patient. It believed that the proposed introduction of an annual amount, paid to the Royal Colleges to reimburse trusts, would compromise the independence, neutrality and objectivity of the Royal Colleges, and that the incentive for consultants to carry out the arduous, difficult work for the Royal Colleges would be removed, to the detriment of quality and safety of healthcare. The British Medical Association queried why the Colleges were being singled out in this way. It said that delivery to the NHS should matter, not the office held.

9.26 We discussed this issue with the parties who attended for oral evidence:

- the British Medical Association told us that it would be unusual for an award to be given just for Royal College work. It believed that it would be unfair to exclude Royal College work from the scheme, as it would discourage doctors from doing such work in future;
- NHS Employers said that Royal College work needed to be considered as part of a new scheme, for example the identified tasks for taking part in Royal College work, what would be expected in the role and what would be 'above and beyond', and what the work contributed to the NHS;
- the Universities and Colleges Employers Association queried how Royal College work was perceived to differ from other NHS work and why such work might not be worthy of an award. It stressed the importance of such work for the NHS;
- ACCEA stressed that the quality of medical education was driven by the Royal Colleges. It did not want to move to a system whereby Royal College work was paid for through Programmed Activities, which it considered could end up costing the NHS more overall; and
- the Academy of Medical Royal Colleges agreed that, in the past, Clinical Excellence Awards might have been given merely for being involved in Royal College work, but said that the emphasis had long since moved to an analysis of actual outcomes.

9.27 *We have not received any evidence to convince us that national awards should not recognise exceptional work for the Royal Colleges. It is not obvious to us whether the Department of Health's proposal to pay for Royal College work outside of the award schemes would be more cost-effective. In any case, we think that all work done for the NHS should be capable of being rewarded and that success should be determined by whether the outcomes of such work are significantly above expectations. We believe therefore that work undertaken for the Royal Colleges should continue to be recognised through the award schemes, where appropriate.*

Recommendation 10: We recommend that work undertaken for the Royal Colleges should continue to be recognised through the award schemes, where appropriate.

Public health consultants and Directors of Public Health

9.28 We note the concern of the Chief Medical Officer and the British Medical Association that the forthcoming changes in England to the employment arrangements of public health consultants and Directors of Public Health could mean that, unless the rules and guidance for the scheme are amended, they may no longer be eligible for the award schemes. Furthermore, the Faculty of Public Health proposed the possible addition of a domain to examine the impact of an applicant's contribution on population health.

9.29 *In our view, as these individuals are carrying out work for the NHS, they should continue to be eligible for the award schemes and the rules and guidance should be amended to ensure their continued inclusion in the schemes.*

Recommendation 11: We recommend that public health consultants and Directors of Public Health should continue to be eligible for the award schemes and that, in the light of the forthcoming changes in England to their employment arrangements, the rules and guidance should be amended to ensure their continued inclusion in the schemes.

Fairness and equity

9.30 Fairness and equity form an important element in the implicit contract between employer and employee:

- the Clinical Genetics Society had significant concerns about the absence of part-time clinicians amongst the award holders;
- the Medical Women's Federation, Royal College of Physicians of Edinburgh and one individual all thought that the scheme should better assess the contribution of part-time consultants, so that they were not discriminated against;
- the Hospital Consultants and Specialists Association and the Medical Women's Federation believed that the current arrangements were not necessarily fair or representative of female candidates;
- the Medical Women's Federation also noted that data gathered by ACCEA had shown that female clinicians with local Clinical Excellence Awards were clustered at the lower end of the scale. It was concerned that, at local level, the award processes were open to bias and inappropriate allocation within trusts;
- the Faculty of Occupational Medicine stressed the importance of the maximum achievable salary for the recruitment of new consultants and suggested that reforms that reduced the pay of senior doctors substantially would be unfortunate at a time when the younger cohorts of doctors in which women predominated were just reaching the stage when they would be eligible for Clinical Excellence Awards in larger numbers;

- ACCEA pointed out that the analysis of the national awards process in its annual reports suggested that the under-representation of females in the national awards reflected fewer applications, not the different treatment of women in the evaluation process. It also noted that in 2009 the success rates for women at gold and platinum level were higher than for men. Nevertheless, ACCEA has accepted, and commented on in its 2010 Annual Report,² some grounds for concern about the distribution of local awards to women and people from black and minority ethnic groups, where they were more likely to hold awards at lower levels than male and white consultants respectively. Recent analysis by ACCEA had also identified that no awards were made to part-time consultants in 2010. ACCEA said that a view would need to be taken on how employer-based awards should be addressed in the devolved NHS that would follow the implementation of the proposals in the White Paper *Equity and Excellence*.³ It said that view would need to take into account the risk of challenge to the NHS on pay equality grounds as it said that further evaluation was required of the patterns of under-representation. During oral evidence, ACCEA told us that it had hoped to tackle the diversity issues arising from the allocation of Clinical Excellence Awards, but plans had been put on hold as they had involved working with the Strategic Health Authorities, which were being abolished under the new NHS plans. In the meantime, it devoted time to women and ethnic minorities in supporting them to make good applications;
- NICEAC favoured self-nomination and pointed out that applicants in Northern Ireland did not need the support of their employer;
- the Royal College of Obstetricians and Gynaecologists told us that it supported equity and equality but that excellence must be the dominant principle;
- the British Medical Association was satisfied that reasonable efforts were made to counteract direct or indirect discrimination, and said that the central monitoring of the distribution of local awards had been instrumental in moving towards a fairer system; however,
- NHS Employers were critical of aspects of the equality proofing of the scheme. For example, they expressed concern that the proportion of eligible women doctors who applied for awards was often less than that of male doctors. Employers were also concerned about the equality and diversity impact of the scheme, and about actual and perceived bias towards clinical academics.

9.31 *In our Thirty-Eighth Report⁴ we sought confirmation from the awarding bodies that the schemes were being operated in accordance with equality legislation. We noted in our Thirty-Ninth Report⁵ our satisfaction that the schemes were being operated appropriately and asked the parties to continue to let us know for future rounds whether there were any issues that may raise concerns regarding equality legislation. We are pleased to note the efforts of ACCEA in assisting women and those from ethnic minorities to make good applications, and the attention being paid to diversity issues resulting from the distribution of awards. We would like to see the awarding bodies continuing to monitor these issues and taking appropriate action to address any inequalities. On a more general level, transparency, fairness and equity are*

² Advisory Committee on Clinical Excellence Awards. *Annual Report covering the 2010 awards round*. ACCEA, November 2010: 1. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121391?ssSourceSiteId=ab.

³ *Equity and excellence: liberating the NHS*. Department of Health, July 2010. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

⁴ Review Body on Doctors' and Dentists' Remuneration. *Thirty-eighth Report*. Cm 7579. TSO, 2009: paras. 8.22, 8.27, 8.38. Available from: http://www.ome.uk.com/DDRB_Main_Reports.aspx

⁵ Review Body on Doctors' and Dentists' Remuneration. *Thirty-ninth Report*. Cm 7837. TSO, 2010: para. 7.21. Available from: http://www.ome.uk.com/DDRB_Main_Reports.aspx

included in the United Kingdom-wide framework of common principles and governance under which we believe that all local and national schemes should operate; these principles are listed in Chapters 5 and 6.

- 9.32 *A number of respondents to our consultation questioned whether it was fair and equitable that the scheme should be confined to consultants. We have made some observations on this issue in Chapter 4, but it would be outside our remit to make recommendations with regard to any group other than consultants or clinical academics with honorary NHS contracts.*

Governance

- 9.33 We received evidence from two individuals expressing serious concern about the operation of the employer-based and national committees. One individual, who was a holder of a level 6 Clinical Excellence Award, told us about what she saw as a conflict of interest whereby medical directors, who were dependent on clinical directors to deliver a service, were unable to side with dissenting individuals on the employer-based awards committee as this would undermine their relationship. She believed that the scores were achieved by “serial collusion” and noted the absence of a lay member chair to argue the case. The second individual, a lay member on a regional sub-committee, criticised what she perceived as the overruling of the regional sub-committee by the national representatives to such an extent that she felt that there was no fairness, transparency or uniform criteria in the process.
- 9.34 We note from ACCEA’s 2010 annual report⁶ that the Chair and Medical Director of ACCEA took a lead role in reviewing the shortlisted applications for bronze awards in 2010, which we understand from the annual report to be the usual process following scoring and shortlisting by the regional sub-committees in parallel with the national nominating bodies.
- 9.35 During oral evidence the DHSSPSNI told us that it considered governance of the scheme at local level to be vulnerable as there was no monitoring of the central guidance on the scheme and it believed that a more consistent approach was warranted. Governance at a national level, however, it believed to be strong, open and transparent.
- 9.36 We heard from SACDA during oral evidence that the current balance of the committee for the national awards was five lay members and seven clinicians; it considered that half and half would be more appropriate. Asked whether medical input could be on an advisory basis, it said that it was important to get a range of views. It did not think that an all lay committee would work as well as a mixed committee. The North East sub-committee of ACCEA argued, in written evidence, that it would be counter-productive to reduce the number of sub-committees as this would lead to fewer organisations covering a wider area and it would be difficult to ensure effective local participation without very large committees. It believed that the possession of very local ‘intelligence’ was an important factor in considering applications.
- 9.37 *We are conscious that the scoring of local awards is a substantial administrative task and that around half the assessment panel is drawn from the consultant body, including consultants from each hospital division. We are also aware that, by having award holders making assessments for both local and national awards, there could be accusations of there being an ‘old boys’ network’. However, as we have explained in Chapter 5, under the new local awards scheme it would no longer be necessary for individual consultants to apply for awards; employers would make the decisions as to which of their consultants were the most deserving in any one year by an assessment of their job performance.*

⁶ Advisory Committee on Clinical Excellence Awards. *Annual Report covering the 2010 awards round*. ACCEA, November 2010: para. 1.3. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121391?ssSourceSiteId=ab.

- 9.38 *We note that the recipients of awards are skewed across specialties, and that the assessors of applications are also likely to be similarly skewed across specialties, creating a vicious circle in which some specialties are under-represented in national awards. We have therefore considered whether clinicians might only advise on applications and the number of lay members assessing applications be increased. We explored this possibility during oral evidence, and the parties told us that the scoring of applications was in broad agreement, regardless of the status of the person assessing the application.*
- 9.39 *We have no means of knowing the extent to which individuals' criticisms of the national and employer-based awards committees reflect widespread practice, although we did raise the issues during oral evidence. However, we believe that it is important that the assessments for national award holders should have input from clinicians, employers and lay members, with the ultimate decisions resting with national awards committees. We do not believe it is appropriate for the Chair and Medical Director of national awards committees to be the final decision makers. We are not convinced that the current composition of members in the national awards committees is the most appropriate, where clinicians form half the total with employers and lay members making up the remainder. In our view an equal ratio (for example, 6:6:6) of clinicians (some of whom may be academics), employers and lay members would be a more balanced committee. We recommend in Chapter 5 that all existing local awards should be subject to regular review. We believe that the employer-based awards committees that conduct such reviews should have a similar constitution to that of the national awards committees.*

Recommendation 12: We recommend that, in order to form a balanced committee, the composition of members in the national awards committees should be comprised of an equal ratio (for example, 6:6:6) of clinicians (some of whom may be academics), employers and lay members, and that the ultimate decisions on national awards should rest with the national awards committees. We recommend that employer-based awards committees conducting reviews of existing local awards should have a similar constitution to that of the national awards committees.

CHAPTER 10 – AFFORDABILITY AND TRANSITION ARRANGEMENTS

- 10.1 In this chapter we look at the costs of our recommendations and proposals as they relate to England.¹ We also make some comments on the accrued rights of individuals and look at some of the arrangements, which we believe would ease the transition to meet our recommendations. Our detailed recommendations relating to local and national awards and to the pensionability of the schemes are given earlier in this report, in Chapters 5, 6 and 8 respectively.
- 10.2 We are required by the terms of reference² to provide assurance that any system for the future includes a process which provides value for money; also, when making our recommendations, to take full account of affordability and to respect the accrued rights of individuals.

Affordability and value for money

- 10.3 The affordability and demonstrable value for money of any scheme is an important consideration. In its evidence, the Department of Health emphasised that arrangements must be affordable and it sought a slimmer system of national payments. It stated that the new arrangements should be as consistent as possible with other public sector remuneration systems. The Scottish Government Health Department said that the scheme must be reformed to be more cost effective; its suggestions included the use of one-off non-consolidated awards and non-financial rewards. The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) said that it was difficult to justify the payment of awards at the expense of bed, ward or service closures and that affordability must be an annual consideration, and NHS Employers queried whether the scheme as currently designed was affordable. The North Eastern sub-committee of the Advisory Committee on Clinical Excellence Awards (ACCEA) pointed out that the need to demonstrate value for money was already covered in the criteria that had to be satisfied for an award. The Department of Health, the DHSSPSNI and the Scottish Advisory Committee on Distinction Awards (SACDA) all proposed that awards should be non-consolidated and held for a limited time. NHS Employers also opposed the consolidation of awards into basic pay, so that additional Programmed Activities attracted *pro rata* increases to the amounts in payment. The Department of Health said that awards should be made for one year, while SACDA suggested periods of between three and five years. ACCEA argued that the awards should be for five years, while the Academy of Medical Sciences and two individuals said that awards should be for a fixed period.
- 10.4 The DHSSPSNI believed that awards should not carry the same level of value as they currently did and said that it would support moves to reduce the monetary value of the national awards, although it recognised the need for a United Kingdom-wide approach. It told us in oral evidence that the current scheme was only considered affordable because not all trusts fully funded the scheme to the agreed 0.25 awards per eligible consultant. The Northern Ireland Clinical Excellence Awards Committee also commented in oral evidence on the history of awards not being funded properly in Northern Ireland.
- 10.5 *We believe that local employers should have freedom over decisions about local award schemes, including the amount spent, although we also consider it important that all employing organisations have in place a local scheme to recognise the valuable contribution made by consultants to delivering the objectives of employing organisations. We do have some reservations about the funding and affordability of local schemes, and suggest that, nationally, the parties should agree a cap on the cost of local schemes. We believe that national schemes*

¹ Costs relate to England only, as this is the only United Kingdom country for which we had sufficient data to carry out our analysis.

² The full terms of reference for the review are given in Appendix A.

should continue to be funded centrally. We have outlined our proposal for a principal consultant grade in Chapter 4. For clinical academics, we believe that the universities should pay an appropriate level of remuneration necessary to recruit and retain sufficient numbers of suitably qualified and experienced clinical academics. In addition, we set out in Chapter 7 our belief that clinical academics should continue to have access to the award schemes.

- 10.6 *It is difficult to assess how much value for money the current schemes offer; to an extent this is a matter of perception, as the schemes are not formally linked to outcomes. We recognise that the awards are perceived by the medical profession as having a strong influence on recruitment and retention, and provide both an incentive to work beyond the job role and recognition for doing so. However, we are concerned that awards should not reward activity already remunerated elsewhere, for example through additional Programmed Activities or Supporting Professional Activities, unless the outcomes are significantly above expectations.*
- 10.7 *In the new schemes, we would like to see a stronger link to performance with improved links to measures of activity, quality of patient care, patient feedback, cost and a clear definition of excellence for each discipline. We believe that it would be most appropriate for the Royal Colleges and equivalent bodies to determine these definitions of excellence. We think it is important that the operation of the schemes should provide a level of assurance that only the highest performing consultants are in receipt of an award. The type of awards that we have recommended will have to be re-earned and we believe they should also have a more immediate impact on motivation and engagement. We consider it inappropriate for awards to be used, to all intents and purposes, as an extension of basic pay, as is the case at present, and we believe that it is essential that the award schemes should be run in a transparent, fair and equitable way. Our costings later in this chapter based on data for England suggest that, at any one time, it would be affordable for 25 per cent of consultants to hold local awards and 10 per cent of consultants to hold national awards. We believe that this will provide a real opportunity for the contributions of the highest performing consultants to be recognised.*

Recommendation 13: We recommend that, in order to obtain value for money from the consultants' award schemes, there should be a stronger link to performance with improved links to measures of activity, quality of patient care, patient feedback, cost and a clear definition of excellence for each discipline. We recommend that the Royal Colleges and equivalent bodies define 'excellence' for their disciplines.

- 10.8 *We think that awards should only be for the highest performing consultants. We have explained in Chapters 5 and 6 how we think the new schemes should look. At national level we think that 10 per cent of consultants should be able to hold national awards; the proportion at local level is for local discretion, although we think that 25 per cent would be an appropriate number. For local awards, we have recommended that schemes should operate within a competitive environment, to reward a limited percentage of consultants working for an employing organisation within any one year.*
- 10.9 *Non-pay incentives could also form an important part of the total reward package for consultants and can contribute to motivation in a cost-effective way. We address the issue of non-financial reward in Chapter 4.*

Affordability of our recommendations

- 10.10 *We describe in this section how we have calculated the cost of our recommendations and proposals. All data relate to England only, as this is the only United Kingdom country for which we had sufficient data to carry out our analysis.*
- 10.11 *As a result of the way in which current schemes operate – awards are permanent, subject to satisfactory review, with pay protection for individuals after an award has been withdrawn –*

the majority of the funding for awards is tied up in payments to existing award holders. Our calculations assume that the funding envelope for new awards is restricted to that which is freed up by consultants retiring or otherwise leaving the NHS, as well as the funding released through the removal of future pension accrual for existing awards. We have not accounted for other factors such as existing award holders choosing to move to the new schemes or consultants having their existing awards withdrawn following an unsuccessful review.

Leaving rates

10.12 Data from the NHS Information Centre on leaving rates for consultants from the NHS in England between September 2009 and September 2010 are shown in Table 10.1, broken down by age group. In general, the leaving rate increases with age, as would be expected. Overall, the leaving rate was 4.9 per cent, and we are content that this is an appropriate figure to use.³

Table 10.1: Leaving rates from the NHS in England, by age group, September 2009 to September 2010

Age Group	Leaving rate from age group
30 to 34	2.9%
35 to 39	3.6%
40 to 44	2.7%
45 to 49	2.3%
50 to 54	2.6%
55 to 59	5.1%
60 to 64	17.8%
65 to 69	47.8%
70 to 74	37.9%
75 to 79	22.2%
Total	4.9%

Source: NHS Information Centre.

Funding released for new award schemes

10.13 *We have stated in Chapter 8 that, under the recommended changes to award schemes, it is no longer appropriate for awards to be pensionable. We also recommend that existing awards are no longer pensionable for future service. We estimate that the costs of employers' pension contributions for local and national awards in England are £24.6 million and £21.9 million respectively.*

10.14 *Data provided by the Department of Health show that older consultants are more likely to be national award holders (see Figure 6.3). Both local and national awards are progressive systems, hence the highest levels of local and national awards tend, on average, to be held by older consultants. Taking this, and the leaving rates above, into account, it is possible to model the amount of funding made available through consultants leaving the NHS. Table 10.2 shows the results of this modelling: we estimate that nearly half of the current spending on local and national awards in England could be available to fund new awards within six years.*

³ Data for 2008-09 are not available. However, leaving rates in 2007-08 were 5.0 per cent; in 2006-07, 7.2 per cent; and in 2005-06, 6.3 per cent. The data for 2009-10, being the lowest figure of all years available, therefore represent the most cautious estimate of the number of consultants leaving the NHS.

Table 10.2: Existing local and national awards: funding released by consultants leaving the NHS in England (including immediate cessation of employers' pension contributions)

Year	Existing local awards				Existing national awards			
	Remaining cost £m	Saving: year on year £m	Saving: cumulative £m	Saving: cumulative %	Remaining cost £m	Saving: year on year £m	Saving: cumulative £m	Saving: cumulative %
Year 0	200.4	24.6	24.6	11.0	178.1	21.9	21.9	11.0
Year 1	185.2	15.2	39.8	17.7	161.6	16.5	38.4	19.2
Year 2	170.6	14.6	54.4	24.2	146.0	15.6	54.0	27.0
Year 3	156.5	14.1	68.5	30.5	131.3	14.8	68.7	34.4
Year 4	143.0	13.5	82.0	36.5	117.4	13.9	82.6	41.3
Year 5	130.0	12.9	95.0	42.2	104.3	13.1	95.7	47.9
Year 6	117.7	12.4	107.3	47.7	92.0	12.3	108.0	54.0
Year 7	105.9	11.8	119.1	52.9	80.5	11.5	119.5	59.8
Year 8	94.6	11.3	130.4	58.0	69.6	10.8	130.4	65.2
Year 9	83.9	10.7	141.1	62.7	59.6	10.1	140.4	70.2
Year 10	73.9	10.0	151.1	67.1	50.3	9.3	149.7	74.8
Year 11	64.6	9.3	160.4	71.3	41.9	8.4	158.1	79.0
Year 12	56.0	8.6	169.0	75.1	34.4	7.5	165.6	82.8
Year 13	48.1	7.9	176.9	78.6	27.7	6.7	172.3	86.1
Year 14	40.8	7.2	184.2	81.8	21.9	5.8	178.1	89.1
Year 15	34.3	6.5	190.7	84.7	16.9	5.0	183.1	91.5

Source: Office of Manpower Economics estimates based on data from the NHS Information Centre and ACCEA.

Redistribution of funding from national to local schemes

10.15 *At present, payment of national awards subsumes the payment of any local awards. Under our recommended approach, local and national schemes would operate in parallel, and it would be possible for consultants to hold both a local and a national award simultaneously.*

10.16 *We assume that, when consultants obtain a national award, they continue to make a contribution at a local level that would continue to merit the payment of their former local award. It therefore seems sensible that, when consultants holding existing national awards leave the NHS, the 'local element' of the funding should be returned to employing organisations, in order to facilitate the implementation of new local award schemes and the principal consultant grade.*

10.17 *Figure 6.4 shows that the median local award held by consultants prior to obtaining a bronze national award was level 6, which currently has a cash value of £17,742. We suggest that this amount should be transferred from national to local funds for every existing national award holder that leaves the NHS. Table 10.3 shows the amount of funding available for new local and national schemes under this approach.*

Table 10.3: Allocation of funding for local and national awards

Year	Existing local and national awards Cost of awards in payment £m	New schemes		
		Funding available for new schemes £m	Allocation for new local awards and principal consultant grade £m	Allocation for new national awards £m
Year 0	378.4	46.6	24.6	21.9
Year 1	346.8	78.2	45.9	32.3
Year 2	316.6	108.4	66.4	42.0
Year 3	287.8	137.2	86.1	51.2
Year 4	260.3	164.7	105.0	59.7
Year 5	234.3	190.7	123.0	67.7
Year 6	209.7	215.3	140.2	75.1
Year 7	186.4	238.6	156.7	82.0
Year 8	164.3	260.7	172.4	88.4
Year 9	143.5	281.5	187.2	94.3
Year 10	124.2	300.8	201.1	99.7
Year 11	106.5	318.5	214.0	104.5
Year 12	90.4	334.6	225.8	108.8
Year 13	75.8	349.2	236.7	112.5
Year 14	62.7	362.3	246.5	115.8
Year 15	51.3	373.7	255.2	118.5

Source: Office of Manpower Economics estimates based on data from the NHS Information Centre and ACCEA.

Cost of new national awards

10.18 Chapter 6 sets out our proposed approach to national awards, and Table 10.4 below provides an illustration of the costs of transition to the new scheme. In this example, the entire cost of the new scheme is met through using funding released through current national award holders leaving the NHS, making the new scheme cost-neutral for the first eight years, and delivering savings from year nine onwards that could be reinvested in other elements of the integrated package for consultants. Assuming no increase in the consultant population, **we estimate that the cost of the new national award scheme would be £91.2 million, compared with a current spending of £200 million.**

10.19 Though we leave it to the parties to agree on the name of the new awards, for the purposes of this illustration we have used the titles alpha, beta, gamma and delta, which we have taken to be equivalent to platinum, gold, silver and bronze Clinical Excellence Awards respectively.

10.20 Including clinical academics, our remit group is 40,055 in England (headcount); by the end of the ninth year of the new scheme, new national awards could be in payment to 10 per cent of our remit group.

Table 10.4: Transition to a new national award scheme (England)

Level	Ratio	Value £	Number of awards								
			Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
Alpha	1	40,000	142	185	225	262	297	330	360	388	401
Beta	2	30,000	284	369	450	525	595	660	720	777	801
Gamma	3	20,000	426	554	674	787	892	990	1,081	1,165	1,202
Delta	4	10,000	568	738	899	1,050	1,190	1,320	1,441	1,553	1,602
Cost of awards (inc. employers' NI contributions) £m			32.3	42.0	51.2	59.7	67.7	75.1	82.0	88.4	91.2

Source: Office of Manpower Economics estimates.

10.21 Figures 10.1 to 10.4 highlight the estimated balance over time between new and existing national awards in payment, illustrating the length of time it could take for existing awards to be phased out. These figures do not take into account an allowance for existing award holders moving to the new scheme, and assumes that all existing award holders successfully retain their awards until they leave the NHS.

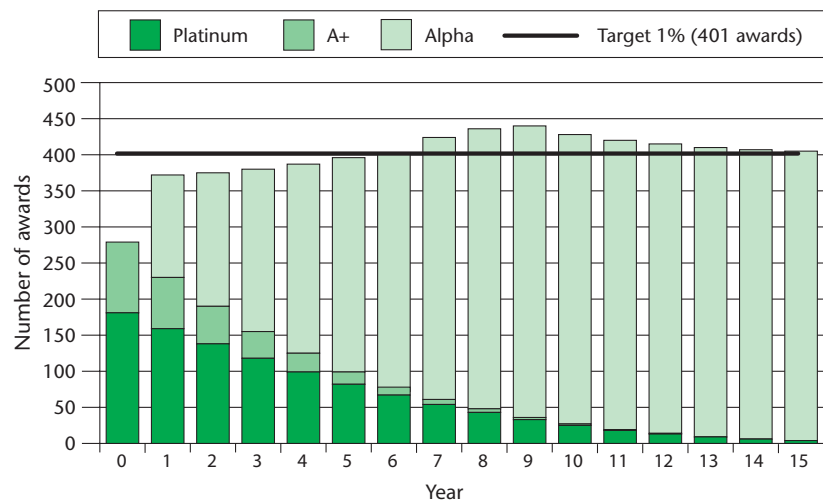
10.22 Since existing platinum and gold Clinical Excellence Awards and A+ and A Distinction Awards are predominately awarded to consultants aged over 55, transition to the new alpha and beta awards would be relatively swift; this would not be the case for new gamma and delta awards. For delta awards in particular, as our recommended approach changes the percentage of award holders at this level from 5.6 per cent to 4 per cent, the total number of awards at this level (old and new) remains well in excess of the 4 per cent target for a number of years; however, it could be argued that existing holders of bronze and B awards may be the most likely to transfer to the new scheme at a higher level.

Cost of new local awards

10.23 Chapter 5 describes an approach whereby around a quarter of consultants would receive a local award in any one year: Table 10.5 below provides an illustration of how this could be structured, with a minimum value of £5,000 and a maximum of £35,000 – broadly in line with the current maximum for local Clinical Excellence Awards.

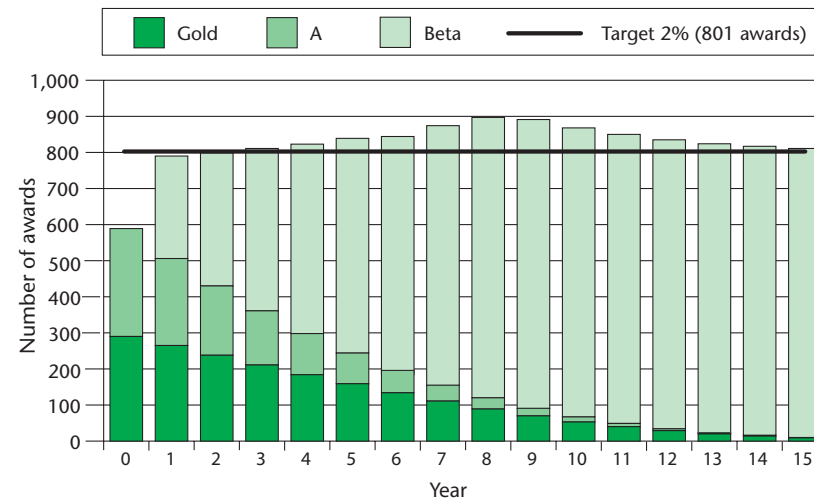
10.24 Overall, we estimate that this approach would cost around £140 million, including employers' National Insurance contributions of 13.8 per cent; the current spending on local awards in England is around £225 million. The results of our modelling shown in Table 10.3 suggest that it could take six years for full implementation of this illustrative approach, though this does not take account of the funding for the principal consultant grade (see below), the cost of which we have assumed would be borne by individual employers. In the interim, employers may choose to make fewer and/or smaller awards.

Figure 10.1: Transition to alpha awards



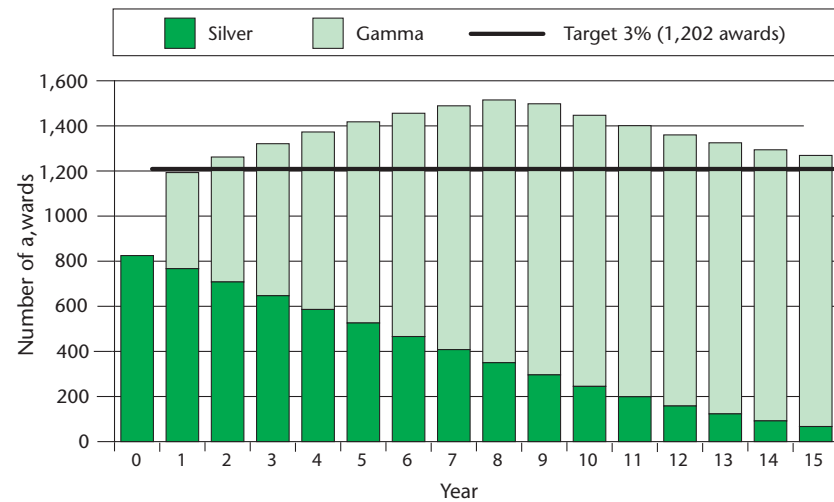
Source: Office of Manpower Economics calculations based on data from the NHS Information Centre and ACCEA.

Figure 10.2: Transition to beta awards



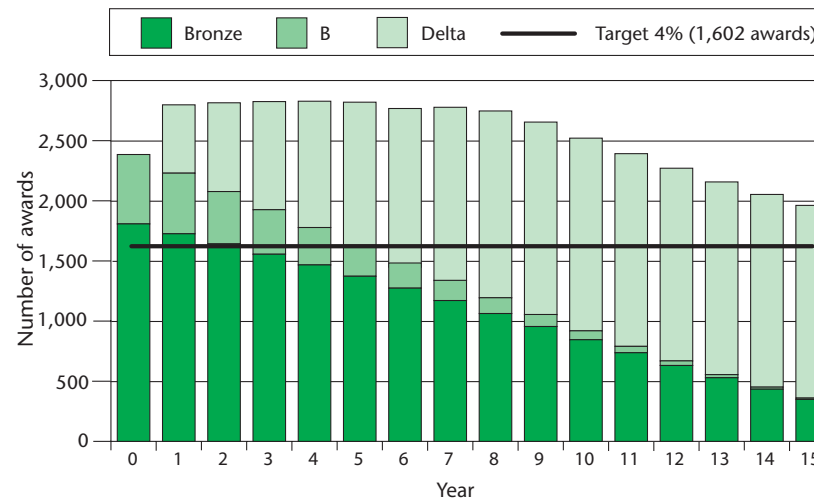
Source: Office of Manpower Economics calculations based on data from the NHS Information Centre and ACCEA.

Figure 10.3: Transition to gamma awards



Source: Office of Manpower Economics calculations based on data from the NHS Information Centre and ACCEA.

Figure 10.4: Transition to delta awards



Source: Office of Manpower Economics calculations based on data from the NHS Information Centre and ACCEA.

Table 10.5: Illustrative structure of new local awards

Percentage of consultants in receipt of award	Award value £	Award percentage at £89,600 average salary	Award percentage at min scale value (£74,504)	Award percentage at max scale value (£100,446)
3%	35,000	39%	47%	35%
4%	25,000	28%	34%	25%
7%	15,000	17%	20%	15%
11%	5,000	6%	7%	5%
75%	0	0%	0%	0%
Average % of base salary		4.1%		

Cost of a new principal consultant grade

10.25 Chapter 4 set out our observations on the basic pay scales for consultants, and suggested that the parties should explore the option of a principal consultant grade. Though we leave it to the parties to discuss the detail, below we set out an illustrative approach and estimated costs.

10.26 Though we have set out our view that there should be a pay range for principal consultants, when estimating the cost of this approach we have assumed for simplicity that: the principal consultant grade would consist of three incremental points; the first point would be set 10 per cent above each individual consultant’s basic salary; the second, £110,000; and the third, £120,000. Consultants at the top of the consultant pay scale (currently £100,446) would move to the second point of the principal consultant scale. Progression through the scale would be based on performance.

10.27 We suggest that, at any one time, around 10 per cent of consultants would be in the principal consultant grade. Though all consultants, regardless of age, would be eligible to apply, we have assumed that the likelihood of promotion to the grade increases with experience.

10.28 **We estimate that the immediate cost of transition to the new structure would be £44 million in England**, including employers’ National Insurance and pension contributions. If, after ten years, all principal consultants were at the top of the range – though this is an unlikely scenario because of consultants retiring and being replaced with new appointees to the grade – **we estimate this would cost £105 million**.

10.29 We have noted in Chapter 4 that we are content with the overall level of compensation for consultants, and our illustrative examples of new local and national award schemes, and the creation of a new principal consultant grade, together provide consultants with the potential to obtain similar levels of earnings to the current system. In addition, the cost of our examples above, which comes to £275 million to £335 million in total (compared with the current spending of £427 million), could be met through using funds freed up by consultants leaving the NHS who currently hold local and national Clinical Excellence Awards in England.

10.30 We note, however, that based on our assumptions it could take up to nine years to fully implement our example schemes, and it would take a number of years for existing schemes to be phased out. This will limit the funding available for the new schemes in the short to medium term. We think it appropriate that some of the funding for existing national awards should be transferred to employing organisations to add to the funding for the new local schemes and implementation of the new principal consultant grade.

Recommendation 14: We recommend that the parties give consideration to how the funding released from existing national awards is redistributed to employing organisations to add to the funding for the new local schemes and implementation of the new principal consultant grade.

Accrued rights

10.31 In its evidence, the Department of Health gave its view on the accrued rights for consultants. These were as follows:

- “Be able to apply for a new award or a higher level of whatever scheme is operating.
- Retain, subject to satisfactory periodic review, an award at the cash value at which it was granted and with any increase in value. The process for review is changed from time to time. The current review process does not represent an accrued right.
- For the cash value of an existing award to be pensionable for past service, on the basis of the rules of the NHS pension scheme to which they belong, although this can be changed for future service.
- The right of appeal against process failures in the administration of the scheme.”

10.32 The Department of Health pointed out in supplementary evidence that many of the provisions which had existed previously had been altered following consultation and the former provisions did not represent an accrued right.

10.33 We asked some of the parties for their comments on the Department’s interpretation of accrued rights and explored the issue at oral evidence. The British Medical Association took the view that the Department of Health appeared to be attempting to limit consultants’ accrued rights. It said that all accrued rights should be maintained and respected regardless of other changes that may be introduced. It noted the absence of pay protection in the list and made clear that the British Medical Association viewed this as an accrued right; also, that it considered the current review process to be an accrued right. Subsequently, the British Medical Association told us that it strongly opposed any changes to accrued benefits. It said that it accepted that some aspects of the schemes had changed in the past and may change in future, and noted that it had actively sought to develop and improve the scheme in recent years. However, reducing accrued rights would be unacceptable to most consultants and it believed would damage their faith in the reliability of all other accrued rights. In particular, it argued that if awards were no longer to be pensionable, then the value of the awards would need to be increased commensurately if the awards were to continue to offer comparable levels of incentivisation to consultants.

10.34 NHS Employers stressed the need for transitional arrangements following any changes to the schemes that affected accrued rights. They said that they needed to explore the issues surrounding accrued rights and negotiate where necessary. The Universities and Colleges Employers Association confirmed that clinical academics had the same accrued rights as NHS consultants.

10.35 *We believe that it is for the parties to agree the substance of the accrued rights held by existing award holders.*

Transition arrangements

- 10.36 Understandably, the arrangements for transition to the new schemes are likely to be of great concern to individuals, in particular those already in possession of an award. For example, the British Medical Association told us during oral evidence that if the schemes were to be changed, it was important not to maroon doctors in a scheme with no chance of career progression.
- 10.37 *To demonstrate how our proposed integrated package of new local and national awards, and changes to pay scales with progression on basic pay scales linked to performance, and a new principal consultant grade might work in practice, we have calculated some illustrative examples of consultants' career earnings profiles under the current Clinical Excellence Award scheme in England,⁴ and how the earnings profiles might differ for these individuals under our proposed integrated package.*
- 10.38 *Figure 10.5 provides an illustration of career earnings profiles under the current scheme for four consultant examples with differing levels of performance, which we have called: high-flyer; good performer; satisfactory performer; and no Clinical Excellence Award. Earnings profiles are based on ten Programmed Activities, and exclude other sources of additional earnings such as on-call supplements.⁵ For all the examples, the earnings profiles show clearly that consolidated, pensionable earnings continue to grow incrementally throughout each consultant's career.*
- 10.39 *Figure 10.6 illustrates career earnings profiles for consultants with differing levels of performance as before, showing the income consultants could potentially earn under our proposed integrated package. We have assumed for simplicity that all national awards are of three years' duration, and that the current incremental pay scale for consultants is not changed.*
- 10.40 *Table 10.6 sets out our assumptions for how the consultants in our illustrations would perform under the current and proposed schemes.*

⁴ The illustrations shown refer to England, but the findings could be applied equally in other United Kingdom countries for consultants at similar career stages with similar levels of local or national awards.

⁵ In Chapter 1, we highlight that additional sources of earnings (including awards) are worth 32 per cent on average over and above basic pay.

Figure 10.5: Pay progression for consultants under the current system



Source: based on assumptions in Table H.1.

Figure 10.6: Pay progression for consultants under the proposed system



Source: based on assumptions in Table H.1.

108 **Table 10.6: Assumed career profile of consultants under the current and proposed schemes**

		Current system	Proposed integrated package
High-flyer	Basic pay	Progress through the salary scale at the normal rate.	Reaches top of pay scale after 10 years rather than the standard 19. Promoted to principal consultant after 14 years, eventually progresses to £120,000.
	Local awards	Obtain local Clinical Excellence Award point every 2 – 3 years after qualifying.	Receives a local award nearly every year (84 per cent success rate, as opposed to the average 25 per cent) with the size of the award varying over time.
	National awards	Bronze, silver, gold and platinum Clinical Excellence Awards obtained after 10, 14, 19 and 24 years respectively.	National award obtained after six years, further success every three years, and progressively higher awards obtained over time, reaching “alpha” level ⁽¹⁾ at 25 years. Subsequent awards vary in size.
Good performer	Basic pay	Progress through the salary scale at the normal rate.	Progress through the salary scale at the normal rate. Promoted to principal consultant after 28 years.
	Local awards	Obtain local Clinical Excellence Award point typically every 4 years after qualifying.	Receives a local award more than every other year (60 per cent success rate), with the size of the award varying over time.
	National awards	Bronze Clinical Excellence Award obtained after 24 years.	First national “delta” ⁽¹⁾ award obtained after 16 years; further national “delta” or “gamma” awards held throughout career but with some periods of no awards.
Satisfactory performer	Basic pay	Progress through the salary scale at the normal rate.	Progress through the salary scale at the normal rate.
	Local awards	First local Clinical Excellence Award point obtained after 10 years, with additional points every 7 years thereafter.	Local awards obtained typically every 6 years, generally at lower levels.
	National awards	None.	None.
No awards	Basic pay	Progress through the salary scale at the normal rate.	Reaches fifth point of consultant pay scale at usual rate, but progress at a slower rate than usual thereafter, and no progression beyond current sixth point.
	Local awards	None.	None.
	National awards	None.	None.

⁽¹⁾ Table 10.4 describes our proposed approach to national awards, which in descending order have been labelled alpha, beta, gamma and delta.

10.41 *Our assessment of the impact on individuals, in terms of whether they would benefit from switching to the new scheme, is set out in Table 10.7. Their assumed level of award (if any) corresponds with the illustration in Figure 10.6, for example the high-flying consultant with ten years' experience is assumed to hold a bronze Clinical Excellence Award.*

10.42 *In summary, consultants with low-level local awards, and those nearer the start of their careers, would be most likely to move to the new scheme. Those with mid-range local Clinical Excellence Awards, or any national Clinical Excellence Award, would be least likely to move to the new scheme.*

Table 10.7: Likelihood of moving to the new scheme, by experience and performance level

Years' experience	Satisfactory performer	Good performer	High-flyer
Newly qualified (age 32-35)	Assumption: no CEAs. Automatically considered for new awards.	Assumption: no CEAs. Automatically considered for new awards.	Assumption: no CEAs. Automatically considered for new awards.
5 years (age 37-40)	Assumption: no CEAs. Automatically considered for new awards.	Assumption: level 1 CEA (£2,957). Likely to give it up if offered a local award under new scheme.	Assumption: level 2 CEA (£5,914). Likely to give it up if offered a local award under new scheme.
10 years (age 42-45)	Assumption: level 1 CEA (£2,957). Likely to give it up if offered a local award under new scheme.	Assumption: level 2 CEA (£5,914). Likely to give it up if offered a local award under new scheme.	Assumption: bronze national CEA (£35,484). Would likely apply for new national award.
20 years (age 52-55)	Assumption: level 2 CEA (£5,914). Likely to give it up if offered a local award under new scheme.	Assumption: level 5 CEA (£14,785). Likely to apply for national awards. If successful, may give up local award.	Assumption: gold national CEA (£58,305). Unlikely to move to the new integrated package.
30 years (age 62-65)	Assumption: level 3 CEA (£8,871). Likely to give it up if offered a medium/high local award under new scheme.	Assumption: bronze/level 9 (£35,484). Highly unlikely to move to the new integrated package.	Assumption: platinum national CEA (£75,796). Highly unlikely to move to the new integrated package.

10.43 *We are conscious of the importance of appropriate transition arrangements so that, for example, those consultants currently holding awards are not disincentivised by the changes, and encouraged to retire earlier. We also recognise that many individuals have accrued rights under the current and previous schemes and our comments on specific accrued rights appear earlier in this chapter. We would like to see the new schemes for national and local awards introduced at the earliest opportunity and award holders encouraged to move from the existing schemes, as we think it is counter-productive to have legacy schemes that continue for a long time. Our intention is that award holders should not be able to hold awards simultaneously on the old and the new schemes, and that it should be implicit in accepting an award under the new schemes or moving into our proposed new principal consultant grade, that individuals must relinquish any awards under the current or previous schemes. However, as we have recommended elsewhere in the report, it will be possible to hold local and national*

awards at the same time under the new schemes. We would also like the parties to consider carefully ways in which award holders could be encouraged to move from the old schemes for local and national awards to the new, while respecting accrued rights.

Recommendation 15: We recommend that award holders should not be able to hold awards simultaneously on the old and new schemes, and that it should be implicit in accepting an award under the new schemes or moving into our proposed new principal consultant grade, that individuals must relinquish any awards under the current or previous schemes.

Recommendation 16: We recommend that the parties consider carefully ways in which award holders could be encouraged to move from the old schemes for national and local awards to the new, while respecting accrued rights.

10.44 *We have made our recommendation in Chapter 8 that, following a suitable transition period to be determined by the parties, existing awards should no longer be pensionable for future service.*

2012 awards round

10.45 The Management Steering Group of Scottish Employers asked us to recommend suspension of the existing consultant award schemes. It wanted no new awards to be granted, pending a comprehensive review of reward and incentivisation issues for all NHS staff. Subsequently, Nicola Sturgeon, Deputy First Minister and Cabinet Secretary for Health and Wellbeing, announced that, pending the outcome of the DDRB review, there would be no increase in the value of Distinction Awards, no new awards and no progression through the award scheme during 2011-12. She also said that there should be no expectation that work undertaken by consultants from 1 April 2011 would count towards eligibility for Discretionary Points.

10.46 During oral evidence, Earl Howe, the Parliamentary Under Secretary of State for Quality (Lords) said that, as our recommendations would need to be considered carefully and the subject of negotiations with key stakeholders, it seemed likely that a new system would not be introduced before the 2013 round. He said that it would be helpful if our recommendations could include a view on whether a 2012 round should be held while a new scheme was being negotiated and agreed in detail.

10.47 Following this, the Department of Health sent us a formal request to make recommendations on whether there should be an awards round for new Clinical Excellence Awards in England in 2012, the basis of any such awards and decisions about renewals in 2012. It believed that the consultations and negotiations necessary would mean that a new system of awards would not be introduced before the 2013 round. It told us that carrying out a final round under the old (i.e. existing) system would create an additional burden on the workload, that a 2012 round for new awards would tie up expenditure that might otherwise be set aside for awards under the new scheme, and that despite the pay freeze, awards had been made for 2011. The Department of Health recognised that such a decision might be interpreted as a signal that the work of excellent consultants was not valued, or that it would disappoint those who had been expecting to submit an application for the 2012 round. It was also concerned that financial resources should be available to fund the new awards system from 2013. In summary, for the 2012 round, the Department of Health wished to focus on renewals of Clinical Excellence Awards and the establishment of a new scheme, while maximising funds that might be available for the future, although it believed it would be possible

to run a 2012 round with a modest number of awards, possibly one-off and non-pensionable.

- 10.48 ACCEA told us that there were strong arguments for having a new awards round in 2012. For example, consultants were already having to deal with a pay freeze and pension changes, and would be beginning to prepare their applications in expectation of a round taking place. It believed that if new awards ceased for a year, it could lead to scepticism as to whether money would ever again be made available for a new scheme, and that this might in turn lead to demoralisation and demotivation. It argued that the cost of new awards was relatively modest, less than £15 million in 2010, compared to the adverse impact on morale that was being risked.
- 10.49 The British Medical Association expressed great concern over the possibility that there might not be an awards round in 2012 and said that it saw no convincing reason why the impending awards round should not be held. It rejected the suggestion that the administrative effort of carrying out the 2012 round was overly burdensome and pointed out that the structures were already in place and potential candidates would be expecting the opportunity to promote their best work. It said that if a 2012 round was not held there could be a negative impact on consultants' motivation, something which it argued the Department of Health had understated in its supplementary evidence. It believed that removing the opportunity for consultants to apply for an award in the 2012 round would cause "upset".
- 10.50 The Hospital Consultants and Specialists Association argued that it would be premature for trusts to depart from the current scheme. It said that not only would DDRB's independence be undermined if the 2012 scheme were to be available only for renewal applications, but it would also send the signal that amendments to the scheme were being overly influenced by the Department of Health.
- 10.51 *We do not think it is for us to decide whether the award schemes should be suspended in Scotland, nor whether the Department of Health should hold a round for Clinical Excellence Awards in 2012. We believe these to be decisions for the governments, in consultation with the parties. However, while we accept that a consultation on our recommendations could take several months, we would still expect the new schemes based on our recommendations and observations to be launched in 2012 and implemented by 2013.*

Conclusions

- 10.52 *This is a United Kingdom-wide review and our recommendations relate to the United Kingdom as a whole. We are conscious that the four countries may not accept all our recommendations and that in turn there is a risk, depending on the extent of differences between the countries, that this could lead to a cross-border movement of consultants. Other consequences of our recommendations that may occur are that existing award holders may be reluctant to move to the new schemes because they perceive the existing schemes to be more beneficial; or a dual system may arise between award holders on the current and those on the new schemes as a result of the need to respect the accrued rights of existing award holders. It is not our intention that our recommendations should lead to any perverse incentive for existing award holders to retire earlier. As we have said above, we would like to see the new schemes for national and local awards introduced at the earliest opportunity and award holders encouraged to move from the existing schemes, as we think it is counter-productive to have legacy schemes that continue for a long time.*
- 10.53 *Consultants whose performance has declined since gaining an award, or whose performance is unremarkable, are less likely to benefit from our recommendations. However, we hope that the recommendation that all national awards should be subject to a new application, will encourage all consultants to achieve and maintain high standards. Clearly, those who*

have up until now benefitted from what we see as anomalies in the current system, such as retire and return or pay protection, or those who have gained Commitment Awards without having to demonstrate excellence, may be less pleased with our recommendations. However, overall, we think that our recommendations and the United Kingdom-wide framework of common principles and governance upon which the award schemes should operate, alongside improved access to the schemes, represent a positive way forward for the award schemes.

10.54 *Our recommended integrated package, including observations on a career structure for consultants, comprises three elements: local awards; national awards; and changes to pay scales, with progression on basic pay scales linked to performance, and a new principal consultant grade. This is intended to be viewed as an integrated package designed to recruit, retain and motivate consultants. It is, in our view, a balanced and affordable package which can be funded from current budget allocations for award schemes and will provide incentives to consultants at all career stages. High-performing consultants could expect to be recognised by their employers, and some exceptional individuals could expect to be promoted to the principal consultant grade, as well as to hold both local and national awards. We believe that the requirement to re-earn local and national awards regularly will motivate consultants to strive constantly for excellence in the NHS, which will be reflected in the highest level of service delivery and outcomes for patients.*

APPENDIX A

REMIT LETTER AND TERMS OF REFERENCE

*From the Rt Hon Andrew Lansley CBE MP
Secretary of State for Health*



POC1_534596

Ron Amy OBE
Chair Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Kingsgate House
66-74 Victoria Street
London SW1E 6SW

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79 Whitehall
London
SW1A 2NS*

*Tel: 020 7210 3000
mb-safs@dh.gov.uk*

23 AUG 2010

Review of compensation levels and incentives for NHS consultants

I am writing to you on behalf of the UK Health Ministers to commission a UK wide review of compensation levels and incentive systems and the various Clinical Excellence and Distinction Awards Schemes for NHS consultants at both national and local levels.

We are grateful to the DDRB for agreeing to undertake this review. We would like you to submit recommendations by July 2011. It will then be for individual Health Ministers to consider the recommendations.

Attached are the agreed terms of reference. I understand that you provided helpful comments on an earlier draft. The terms of reference have been agreed with the devolved administrations, NHS Employers in England and the BMA. In making recommendations, the review should take account of affordability and the differing funding arrangements between the UK schemes. I would be grateful if your Secretariat could send officials your proposed schedule for the review including timescales for taking written and oral evidence.

Thanks again for agreeing to take on this remit. We look forward to working with you on it over the coming months.

I am copying this letter to my colleagues in the Devolved Administrations.

ANDREW LANSLEY CBE

COMPENSATION LEVELS, INCENTIVES AND THE CLINICAL EXCELLENCE AND DISTINCTION AWARD SCHEMES FOR NHS CONSULTANTS

TERMS OF REFERENCE FOR A UK WIDE REVIEW

The review is to look 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 review will take place in the context of key Government documents and the remit is -

- 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
- 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

The review will be fully linked into other activity on public sector pay including:

- The benchmarking work on senior public sector pay being carried out by the Senior Salaries Review Body;
- The Fair Pay Review in the public sector led by Will Hutton; and
- The review of public service pensions by the Independent Public Service Pensions Committee chaired by John Hutton

The review should consider issues of comparability with other public sector and NHS incentive schemes. The recommendations of the review must take full account of affordability and value for money. The recommendations must also respect the accrued rights of individuals.

The review is to be led by the Review Body on Doctors' and Dentists' Remuneration (DDRB). The DDRB as an independent body will work closely with a range of external stakeholders, including NHS employers, the British Medical Association and the independent Committees which make awards in the four countries.

The review has been commissioned by Ministers of the four countries in the UK.

The DDRB has been asked to submit recommendations to UK Ministers by July 2011.

APPENDIX B

CONSULTATION DOCUMENT

Review Body on Doctors' and Dentists' Remuneration

Chairman: Ron Amy, OBE

**Review of compensation levels, incentives and
the Clinical Excellence and Distinction Award
schemes for NHS consultants**

31 August 2010

1. Introduction and background

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. This introduction gives some details about the current schemes.

The Clinical Excellence Award Scheme rewards those consultants who contribute most towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services including those who do so through their contribution to academic medicine. All levels of award are made against the same criteria to reflect nationally agreed objectives. The objectives of the Clinical Excellence Award Scheme are to reward individuals who perform over and above the standard expected of a consultant in their post, and who locally, nationally or internationally:

- demonstrate sustained commitment to patient care and wellbeing or improving public health;
- sustain high standards of both technical and clinical aspects of service whilst providing patient-focused care;
- in their day-to-day practice demonstrate a sustained commitment to the values and goals of the NHS 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 knowledge base through research and participate actively in research governance;
- are recognised as excellent 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.

Individuals are not expected to meet all of the above criteria to be worthy of an award – much will depend on the type and nature of the post.

The current values of the awards are:

Local awards	
Level 1	£2,957
Level 2	£5,914
Level 3	£8,871
Level 4	£11,828
Level 5	£14,785
Level 6	£17,742
Level 7	£23,656
Level 8	£29,570
Level 9	£35,484
National awards	
Bronze	£35,484
Silver	£46,644
Gold	£58,305
Platinum	£75,796

Levels 1 to 9 are only available in England: Wales replaced Local Awards with a series of commitment awards (each currently valued at £3,204) that are paid at three-yearly intervals after reaching the sixth point of the Welsh consultant pay scale. The Bronze, Silver, Gold and Platinum awards are available in both England and Wales.

Further information on the Clinical Excellence Award Scheme is available at <http://www.dh.gov.uk/ab/ACCEA/Publications/index.htm>.

In Scotland, a framework for a new scheme for distinction awards and discretionary points (the Scottish Consultants' Clinical Leadership and Excellence Awards (SCCLEA) scheme) has recently been agreed, and is intended to reward and incentivise the highest possible standards of clinical activity amongst consultants in Scotland. It is intended to be capable of recognising leadership and excellence in whatever form and whatever place they are found. The scheme should reward individuals who contribute over and above what is contractually expected. The national criteria for the awards fall within six domains:

- improvements in service and achievement of service goals;
- audit, clinical governance, promotion of evidence-based medicine;
- administrative, management and advisory activities;
- research and innovation;
- teaching and training;
- scope and level of professional contribution to the NHS.

It is not expected that a candidate will demonstrate 'over and above' achievement in all domains in order to be worthy of an award.

The value of the awards under the new scheme were suggested as being the following, although Scotland noted that the values could change as a result of further development of the scheme:

Local Excellence Award	
Grade 1	£3,156
Grade 2	£6,312
Grade 3	£9,468
Grade 4	£12,624
Grade 5	£15,780
Grade 6	£18,936
Grade 7	£22,092
Grade 8	£25,248
Grade 9	£28,404
Grade 10	£31,560
National Excellence Award	
Grade 11	£37,872
Grade 12	£53,911
Grade 13	£73,158

Further information on the scheme is available at: <http://www.shsc.scot.nhs.uk/shsc/default.asp?p=71>.

The Northern Ireland Clinical Excellence Awards scheme aims to ensure the recognition of exceptional personal contributions made by individual doctors who show a commitment to achieving the delivery of high quality care to patients and to the continuous improvement of Health and Social Care. In particular, the objectives are:

To reward individuals who perform over and above the standard of a consultant in their post, and who locally, regionally, nationally or internationally:

- 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 Health and Social Care 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.

Individuals will not be expected to meet all of the objectives to be worthy of an award. Much will depend on the nature and type of post held.

The current values of the awards are:

Local awards	
Step 1	£2,957
Step 2	£5,914
Step 3	£8,871
Step 4	£11,828
Step 5	£14,785
Step 6	£17,742
Step 7	£23,656
Step 8	£29,570
National awards	
Step 9	£35,484
Step 10	£46,644
Step 11	£58,305
Step 12	£75,796

Further information on the scheme is available at: http://www.dhsspsni.gov.uk/index/hss/clinical_excellence_awards_scheme.htm.

For all schemes, awards are consolidated into pay and contribute to pension entitlements. Consultants on retirement receive a pension and retirement lump sum which is based on the best of the last three years' pensionable pay (although since 2008, some consultants have moved to a new pension scheme where pensionable pay is based on the average of the best three consecutive years in the last ten).

2. Terms of Reference

The terms of reference for the review are as follows:

"The review is to look 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 review will take place in the context of key Government documents and the remit is -

- 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
- 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

The review will be fully linked into other activity on public sector pay including:

- The benchmarking work on senior public sector pay being carried out by the Senior Salaries Review Body;
- The Fair Pay Review in the public sector led by Will Hutton; and
- The review of public service pensions by the Independent Public Service Pensions Committee chaired by John Hutton

The review should consider issues of comparability with other public sector and NHS incentive schemes. The recommendations of the review must take full account of affordability and value for money. The recommendations must also respect the accrued rights of individuals.

The review is to be led by the Review Body on Doctors' and Dentists' Remuneration (DDRB). The DDRB as an independent body will work closely with a range of external stakeholders, including NHS Employers, the British Medical Association and the independent Committees which make awards in the four countries.

The review has been commissioned by Ministers of the four countries in the UK.

The DDRB has been asked to submit recommendations to UK Ministers by July 2011."

3. Submitting your views

Written responses on this review should be submitted, preferably electronically, by **Friday 26 November 2010** to:

ddrb_cea@bis.gsi.gov.uk

Cliff Wilkes
DDRB Secretariat
Office of Manpower Economics
Kingsgate House
66-74 Victoria Street
London
SW1E 6SW

Fax: 020 7215 4445

Please address any **queries** to Cliff Wilkes at the above address or on 020 7215 8407.

When responding, please state whether you are responding as an individual or representing the views of an organisation. If you are responding on behalf of a representative organisation, please make it clear whom the organisation represents, the size of the membership and, where applicable, how the views of the members were obtained.

4. Confidentiality

If you want the information you provide to be treated as confidential, it would be useful if you could explain to us why you regard the information as confidential. However, in some circumstances we may nevertheless be required to disclose information submitted in confidence under the terms of the Freedom of Information Act.

5. Next steps

DDRB will consider the written responses to this review and invite oral evidence from the main parties in spring 2011. It will take into account all relevant factors raised in evidence. Thereafter, the Review Body will make recommendations in accordance with its terms of reference. The Review Body expects to submit its report to Ministers by July 2011.

APPENDIX C

THE EVIDENCE

We received written evidence from the following individuals and bodies.

Individuals

Allan, Dr Laurie
Appel, Kenneth
Armitage, Dr Mary
Armstrong, Janette
Bardgett, Harry
Barker, Ian
Bloor, Dr Karen and Maynard, Professor Alan
Chappell, Julie
Chowdhury, M
Cohen, David
DeFriend, Diane
Dekker, P
Doull, Dr R I
Gaines, Peter
Glancey, Gerald
Gupta, Dr Rajeev
Halligan, Professor Steve
Harris, Shirley
Helliwell, Dr Tim
Ingham Clark, Celia
Johns, Keith
Johnston, Dr Colin
Jones, Mr Nicholas P
Jory, William
Joseph, Dr Anton E A
Joseph, Dr Anton E A & Croisdale-Appleby, Professor David
Laver, Gill
Lee, Dr John
McCollum, Professor Peter
McKee MBE MSP, Dr Ian
Mitchell, Mrs L
Montgomery, Richard
Morris, Kevin
Napier, Seamus
Nicholls, Eric
Nordin, Dr Andy
Radhakrishna, Dr S
Rew, Mr David
Rivett, Kate

Robb, Peter J
Rothwell, Dr M
Rutter, Dr Matt
Smith, Bob
Wincelous, Dr S J

Bodies

Academy of Medical Royal Colleges
Academy of Medical Sciences/British Heart Foundation/Cancer Research UK/Wellcome Trust
Advisory Committee on Clinical Excellence Awards (ACCEA)
Association for Cancer Surgery
Association of Anaesthetists of Great Britain and Ireland
Association of Consultants and Specialists in Restorative Dentistry
Association of Surgeons of Great Britain and Ireland
Association of UK University Hospitals
British Association for Sexual Health and HIV
British Association of Stroke Physicians
British Cardiovascular Society
British Dental Association
British Medical Association
British Ophthalmic Anaesthesia Society
British Paediatric Neurology Association
British Pain Society
British Society for Gynaecological Endoscopy
British Society for Paediatric Endocrinology and Diabetes
British Society for Rheumatology
British Society of Bone Marrow Transplantation
British Society of Neuroradiologists
British Society of Paediatric Gastroenterology, Hepatology and Nutrition
British Society of Periodontology
British Society of Rehabilitation Medicine
British Society of Urogynaecology
British Thoracic Society
British Transplantation Society
Clinical Genetics Society
Committee of Postgraduate Dental Deans and Directors
Conference of Postgraduate Medical Deans of the United Kingdom
Dental Schools Council
Department of Health
Department of Health, Social Services and Public Safety in Northern Ireland
Faculty of Dental Surgery of the Royal College of Surgeons of England
Faculty of Occupational Medicine
Faculty of Pharmaceutical Medicine of the Royal Colleges of Physicians of the United Kingdom
Faculty of Public Health
Guy's and St Thomas' NHS Foundation Trust

Hospital Consultants & Specialists Association
Leeds Teaching Hospitals NHS Trust
Local Negotiating Committee of Yeovil District Hospital
London North East ACCEA
Management Steering Group of Scottish Employers
Medical Research Council
Medical Schools Council
Medical Women's Federation
Ministry of Defence
National Institute for Health and Clinical Excellence
Neuroanaesthesia Society of Great Britain and Ireland
NHS Employers
North East Sub-Committee, ACCEA
Northern Ireland Clinical Excellence Awards Committee
Novartis Pharmaceuticals UK Ltd
Renal Association
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Royal College of Pathologists
Royal College of Physicians
Royal College of Physicians of Edinburgh
Royal College of Radiologists
Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Sanofi Aventis
Scottish Advisory Committee on Distinction Awards
Scottish Government
Society for Academic Primary Care
Society for Cardiothoracic Surgery in Great Britain & Ireland
Society for Education in Anaesthesia (UK)
Society for Endocrinology
St George's, University of London
Universities and Colleges Employers Association
Universities UK
University of Leicester
University of Oxford
Wales Awards Committee of ACCEA
Welsh Assembly Government
West Midlands ACCEA

All of the evidence we received for this review can be read in full on our website:
http://www.ome.uk.com/DDRB_CEA_review.aspx

APPENDIX D

SALARY SCALES, FEES AND ALLOWANCES FOR CONSULTANTS

PART I: SALARY SCALES

The salary scales for full-time consultant hospital and community health services doctors and dentists are set out below; rates of payment for part-time staff should be *pro rata* those of equivalent full-time staff.

Hospital medical and dental, public health medicine and dental public health staff

	Scales payable from 1 April 2011 £
Consultant (2003 contract, England, Scotland and Northern Ireland for main pay thresholds) ¹	74,504
	76,837
	79,170
	81,502
	83,829
	89,370
	94,911
	100,446
<i>Clinical Excellence Awards</i> ²	2,957
	5,914
	8,871
	11,828
	14,785
	17,742
	23,656
	29,570
	35,484 ³
Consultant (2003 contract, Wales)	72,205
	74,504
	78,350
	82,818
	87,918
	90,827
93,742	

¹ Pay thresholds and transitional arrangements apply.

² Local level Clinical Excellence Awards in England and Northern Ireland. For national Clinical Excellence Awards, see Part II of this Appendix.

³ Step 9 local Clinical Excellence Awards are only made at national level in Northern Ireland.

	Scales payable from 1 April 2011 £
<i>Commitment Awards</i> ⁴	3,204
	6,408
	9,612
	12,816
	16,020
	19,224
	22,428
	25,632
<i>Consultant (pre-2003 contract)</i> ⁵	61,859
	66,285
	70,712
	75,138
	80,186
<i>Discretionary Points</i> ⁶	3,204
	6,408
	9,612
	12,816
	16,020
	19,224
	22,428
	25,632

PART II: FEES AND ALLOWANCES

Operative date

- The levels of remuneration set out below operate from 1 April 2011.

Hospital medical and dental staff

- The annual values of national Clinical Excellence Awards for consultants, clinical academics and academic general medical practitioners are as follows.

Bronze (Level 9):	£35,484
Silver (Level 10):	£46,644
Gold (Level 11):	£58,305
Platinum (Level 12):	£75,796

⁴ Awarded every three years once the basic scale maximum is reached.

⁵ Closed to new entrants.

⁶ From October 2003 in England, and from 2005 in Northern Ireland, local Clinical Excellence Awards have replaced Discretionary Points. From October 2003 in Wales, Commitment Awards have replaced Discretionary Points. Discretionary Points continue to be awarded in Scotland and remain payable to existing holders in England, Wales and Northern Ireland until the holder retires or is awarded a Clinical Excellence Award or Commitment Award.

3. The annual values of Distinction Awards for consultants⁷ are as follows.

B award:	£31,959
A award:	£55,924
A+ award:	£75,889

4. The annual values of consultant intensity payments are the following amounts:

Daytime supplement:	£1,274	
Out-of-hours supplement	(England, Scotland and Northern Ireland)	(Wales)
Band 1:	£960	£2,213
Band 2:	£1,913	£4,426
Band 3:	£2,860	£6,637

5. A consultant on the 2003 Terms and Conditions of Service working on an on-call rota will be paid a supplement in addition to basic salary in respect of his or her availability to work during on-call periods. This is determined by the frequency of the rota they are working and which category they come under. To determine the category, the employing organisation should establish whether typically a consultant is required to return to site to undertake interventions, in which case they should come under category A. If they can typically respond by giving telephone advice, they would come under category B.

The rates are set out in the table below.

Frequency of rota commitment	Value of supplement as a percentage of full-time basic salary	
	Category A	Category B
High Frequency: 1 in 1 to 1 in 4	8.0%	3.0%
Medium Frequency: 1 in 5 to 1 in 8	5.0%	2.0%
Low Frequency: 1 in 9 or less frequent	3.0%	1.0%

London weighting

6. The value of the London zone payment⁸ is £2,162 for non-resident staff and £602 for resident staff.

⁷ From October 2003 in England and Wales, and from 2005 in Northern Ireland, national Clinical Excellence Awards replaced Distinction Awards. Distinction Awards continue to be awarded to eligible consultants in Scotland and remain payable to existing holders in England, Wales and Northern Ireland until the holder retires or is awarded a Clinical Excellence Award.

⁸ Review Body on Doctors' and Dentists' Remuneration. *Thirty-Sixth Report*. Cm 7025. TSO, 2007: para. 1.64.

Doctors in public health medicine

7. The supplements payable to district directors of public health (directors of public health in Scotland, Wales and Northern Ireland) and for regional directors of public health are as follows:⁹

	Current range of supplements £
Island Health Boards: Band E (under 50,000 population)	1,758 – 3,487
District director of public health (director of public health in Scotland/Wales/Northern Ireland):	
Band D (District of 50,000 – 249,999 population)	3,487 – 6,972 (Bar) ⁽¹⁾ 8,717 ⁽²⁾
Band C (District of 250,000 – 449,999 population)	4,374 – 8,717 (Bar) ⁽¹⁾ 10,474 ⁽²⁾
Band B (District of 450,000 and over population)	5,232 – 10,474 (Bar) ⁽¹⁾ 13,511 ⁽²⁾
Regional director of public health: Band A	13,511 – 19,612

Notes:

- (1) Bar is the top of the range but high performers can go above this as long as they do not exceed the exceptional maximum.
- (2) This is the exceptional maximum of the scale.

⁹ Population size is not the sole determinant for placing posts within a particular band.

APPENDIX E

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM NATIONAL SCHEMES

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – CURRENT NATIONAL SCHEMES		ENGLAND and WALES	SCOTLAND	NORTHERN IRELAND
CURRENT SCHEME¹		Clinical Excellence Awards.	Scottish Consultants' Clinical Leadership and Excellence Awards (SCCLEAs).	Clinical Excellence Awards.
Date scheme started		2003.	On hold pending DDRB review – new scheme was due to start in 2011.	2005.
Awarding body		Advisory Committee on Clinical Excellence Awards (ACCEA).	Scottish Advisory Committee on Consultants' Clinical Leadership and Excellence Awards (SACCCLLEA).	Northern Ireland Clinical Excellence Awards Committee (NICEAC).
Value of awards – 1 April 2011		Bronze – £35,484 (equal to a level 9 local award)	Not applicable as the scheme is on hold. However, it was intended that no additional funding would be available for the new scheme.	Step 9 – £35,484 Step 10 – £46,644 Step 11 – £58,305 Step 12 – £75,796
The award of a higher award subsumes the value of any previous award, including local awards and (in Wales) any Commitment Awards.		Silver – £46,644 Gold – £58,305 Platinum – £75,796	Proposed Figures for 2011: Grade 11 – £38,440 Grade 12 – £55,924 Grade 13 – £75,889	

¹ In the case of Scotland, implementation of this scheme has been delayed pending the DDRB review.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – CURRENT NATIONAL SCHEMES

	ENGLAND and WALES	SCOTLAND	NORTHERN IRELAND
Number of awards granted	<p>ACCEA makes awards to as many consultants whose application forms meet the quality criteria, to the extent that is affordable within the available budget. It receives advice from the Department of Health on the NHS budgets (see below). This takes into account the number of awards released through retirements and resignations, withdrawals and progress to a higher award in the previous year, plus recommendations from DDRB on the number of new awards to be made available. Geographical and specialty distribution of the available awards aims to be broadly <i>pro rata</i> to the consultant population and aims to broadly match the proportion of consultants holding each level.</p> <p>Awards decided on a competitive basis, based on the relative merits of individual application forms.</p>	<p>SACCLEA makes awards to as many consultants whose application forms meet the criteria. This takes into account the number of awards released through retirements and resignations, withdrawals and progress to a higher award in the previous year, plus recommendations from DDRB on the number of new awards to be made available. Geographical and specialty distribution of the available awards aims to be broadly <i>pro rata</i> to the consultant population and aims to broadly match the proportion of consultants holding each level.</p> <p>Awards decided on a competitive basis, based on the relative merits of individual application forms.</p>	<p>The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) advises NICEAC of the number of awards available for allocation each year. This takes account of money released through retirements, deaths, resignations plus recommendations made by DDRB. Awards are decided on a competitive basis, using an objective scoring framework, based on the merits of individual cases.</p>

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – CURRENT NATIONAL SCHEMES

	ENGLAND and WALES	SCOTLAND	NORTHERN IRELAND
Budget for scheme	<p>Centrally funded.</p> <p>ACCEA provides the Department of Health with an estimate of committed spend for Clinical Excellence Awards and Distinction Awards and of the net cost of new awards as proposed in its evidence to DDRB.</p> <p>The NHS budget is set by the Department of Health, and the ACCEA award budget is ring fenced within this.</p>	<p>Centrally funded.</p> <p>SACDA/SACCICLEA do not have a budget, they work on the basis of the number of awards available for allocation based on the number of award holders that retire at each level.</p>	<p>Centrally funded.</p> <p>There is a fixed budget set by DHSSPSNI.</p>
Advancement in scheme	<p>There is no fixed time limit that determines whether a consultant should be considered for a bronze award, although it usually takes about ten years.</p> <p>Normally consultants who apply successfully for a national award will have at least a level 4 Clinical Excellence Award, although in exceptional circumstances, bronze awards are made to individuals who have not reached this level. ACCEA publishes detailed analysis of these issues in its reports and explains the position in FAQs on its website.</p>	<p>Normally consultants will have been in a consultant post for at least ten years before applying for a national award.</p>	<p>For higher awards, consultants must have a minimum of four lower awards. NICEAC consider that in most cases it would normally take at least ten years for consultants to progress to step 9 award and a further four years to justify further progression.</p>

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – CURRENT NATIONAL SCHEMES

	ENGLAND and WALES	SCOTLAND	NORTHERN IRELAND
Review and renewal criteria	<p>Five-yearly renewals.</p> <p>Applications are considered against the standard required to obtain a new award. If this is not met then consideration is given to whether the consultant has continued to deliver the contribution for which the award was originally given.</p> <p>Awards are not renewed where performance no longer merits the award or where the award holder has failed to apply for renewal – these are covered by pay protection (payment at higher level continues on mark-time basis).</p> <p>In very extreme circumstances, removal of the award and removal of payment.</p>	<p>Five-yearly reviews.</p> <p>Renewed for less than five years if unable to demonstrate that the criteria for the award continue to be met.</p> <p>Removal of the award where performance no longer merits the award – pay protection (payment at higher level continues on mark-time basis).</p> <p>In very extreme circumstances, removal of the award and removal of payment.</p>	<p>Five-yearly reviews.</p> <p>Renewed for less than five years if unable to demonstrate that the criteria for the award continue to be met.</p> <p>Removal of the award where performance no longer merits the award – pay protection (payment at higher level continues on mark-time basis).</p> <p>In very extreme circumstances, removal of the award and removal of payment.</p>
Equality of opportunity	<p>Awards can only be made on the basis of a consultant's application, which is made on a standard form that is designed to ensure comparable presentation of achievements.</p> <p>Evaluation is made by a twin shortlisting route (sub-committees and national nominating bodies) informed by a scoring system which considers each domain separately.</p>	<p>Self nomination.</p>	<p>Self nomination is the only method of application.</p>

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – CURRENT NATIONAL SCHEMES

	ENGLAND and WALES	SCOTLAND	NORTHERN IRELAND
Current status of scheme	Open.	Scheme frozen pending DDRB review – this is a new scheme which was due to be implemented in 2011.	DHSSPSNI took the decision to make no new awards in 2010-11.
Eligibility	NHS consultants with at least one year's experience at consultant level. Academic general practitioners. Senior clinical academics who hold honorary NHS contracts. Postgraduate deans/heads of schools of medicine/dentistry. Consultants working as NHS trust clinical/medical directors or equivalent. Subject to satisfactory participation in appraisal and job plan; observance of private practice code of conduct; no adverse outcome from disciplinary proceedings. There is no fixed time limit that determines whether a consultant should be considered for a bronze award.	Consultants will normally be on the fifth point of the pay scale (five years) before being eligible for an award. NHS consultants, clinical academics and senior academic general practitioners.	Consultants who have at least three years' experience. Deans. Joint Appointees, based on contribution made to Health and Social Care. Clinical/medical directors of Health and Social Care trusts. Must have achieved a minimum of four lower awards (Clinical Excellence Awards or Discretionary Points). Subject to participation in appraisal and job plan; observance of private practice code of conduct; no adverse outcome from disciplinary proceedings. NB Clinical academic general practitioners are not eligible.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – CURRENT NATIONAL SCHEMES

	ENGLAND and WALES	SCOTLAND	NORTHERN IRELAND
Transparency	Names of successful applicants and examples of their personal statements are published on the ACCEA website for each round. The names and some details of all current award holders are published on the website in the nominal roll. On request from employers (for feedback), or from potential appellants, individual scores, together with the ranking in the sub-committee scoring schedule, can be provided.	Names of successful applicants are published on the website once they have been notified. A full list of all award holders is available in the annual report. Consultants are able to receive information on their individual scores and ranking on request.	The names of successful applicants and their personal statements are published on the DHSSPSNI website. Names of successful applicants are also published in NICEAC's Annual Report which is available on the DHSSPSNI website.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – CURRENT NATIONAL SCHEMES

	ENGLAND and WALES	SCOTLAND	NORTHERN IRELAND
Criteria for selection	<p>Consultants must show that they have performed over and above expectations of a consultant or academic general practitioner in their role. They provide evidence about their performance in five domains to demonstrate:</p> <ul style="list-style-type: none"> • delivery of a high quality service; • development of a high quality service; • leadership and managing a high quality service; • research and managing a high quality service; and • teaching and training. <p>Further details on the interpretation of the criteria, including guidance on what merits high scores, is set out in the Guide for Assessors (available on the ACCEA website).</p>	<p>Consultants must provide evidence about their performance in six domains:</p> <ul style="list-style-type: none"> • improvements in service and achievement of service goals; • audit, clinical governance, promotion of evidence based medicine; • administrative, management and advisory activities; • research and innovation; • teaching and training; and • scope and level of professional contribution to NHS. 	<p>Consultants must provide evidence about their performance in four criteria:</p> <ul style="list-style-type: none"> • delivering a high quality service; • developing a high quality service; • managing a high quality service; and • teaching and training/research.
Pensionability	All levels are pensionable.	All levels are pensionable.	All levels are pensionable.
Retirement and partial retirement	All awards cease on retirement. There is no eligibility for payment of awards on re-employment after the consultant has taken their pension.	All awards cease on retirement. There is no eligibility for payment of awards on re-employment after the consultant has taken their pension.	All awards cease on retirement. There is no eligibility for payment of awards on re-employment after the consultant has taken their pension.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – PREVIOUS NATIONAL SCHEMES		
	ENGLAND and WALES	NORTHERN IRELAND
PREVIOUS SCHEME² – awards remain payable to existing holders until the holder retires or gains a new award.	Distinction Awards.	Distinction and Meritorious Service Awards.
Date scheme started	Originally began in 1948. The modified version of Distinction Awards was introduced in 1990.	1948.
Awarding body	Advisory Committee on Distinction Awards (ACDA) – now replaced by Advisory Committee on Clinical Excellence Awards (ACCEA) which considers renewals of awards.	Distinction and Meritorious Service Awards Committee (DMSAC).
Value of awards – 1 April 2011	B award – £31,959 A award – £55,924 A+ award – £75,889	B award – £31,959 A award – £55,924 A+ award – £75,889
Number of awards granted	Not applicable.	Not applicable.
Budget for scheme	Centrally funded – forms part of the overall Clinical Excellence Award budget (see Clinical Excellence Award information above).	Centrally funded from the budget for higher awards.

² In the case of Scotland, this is effectively the current scheme (although frozen) as implementation of the new scheme has been delayed pending the DDRB review.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – PREVIOUS NATIONAL SCHEMES

	ENGLAND and WALES	SCOTLAND	NORTHERN IRELAND
Advancement in scheme	No further awards made under this scheme; further awards made as Clinical Excellence Awards. Consultants may apply for higher Clinical Excellence Awards according to the level of Distinction Award they hold. B award holders may apply for silver Clinical Excellence Awards and A Award holders may apply for platinum Clinical Excellence Awards.	Normally expected to have held a B award for five years before applying for an A award and a further five years before applying for an A+ award.	No further awards made under this scheme; further awards made as Clinical Excellence Awards.
Review and renewal criteria	Five-yearly renewals. Applications are considered against the standard required to obtain a new award. If this is not met then consideration is given to whether the consultant has continued to deliver the contribution for which the award was originally given. Awards are not renewed where performance no longer merits the award or where the award holder has failed to apply for renewal – these are covered by pay protection (payment at higher level continues on mark-time basis). In very extreme circumstances, removal of the award and removal of payment.	Five-yearly reviews for all awards granted since the 1989 awards round. Supplementary review if individual is unable to demonstrate that the criteria for the award continue to be met. Removal of the award where performance no longer merits the award. Pay protection applies, but the funding has to be met by the employer – it is no longer centrally funded by the government. In very extreme circumstances, removal of the award and removal of payment.	Five-yearly reviews. Renewed for less than five years if unable to demonstrate that the criteria for the award continue to be met. Removal of the award where performance no longer merits the award – pay protection (payment at higher level continues on mark-time basis). In very extreme circumstances, removal of the award and removal of payment.
Equality of opportunity	Not applicable.	Self nomination.	Not applicable.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – PREVIOUS NATIONAL SCHEMES

	ENGLAND and WALES	SCOTLAND	NORTHERN IRELAND
Current status of scheme	No further awards made under this scheme. Awards remain payable to existing holders until the holder retires or gains a new award.	Scheme frozen pending DDRB review.	No further awards made under this scheme. Awards remain payable to existing holders until the holder retires or gains a new award.
Eligibility	Not applicable – no further awards are made under this scheme.	NHS consultants – on the new contract must have reached point 5 on the salary scale; on the old contract must have reached the maximum. Academic general practitioners. Senior clinical academics who hold honorary NHS contracts. Deans. Consultants working in NHS Boards as clinical/medical directors or equivalent. Subject to satisfactory appraisal and job plan; observance of private practice code of conduct; no adverse outcome from disciplinary proceedings. Normally expected to have ten years' experience at consultant grade in their discipline before applying for a B award.	Not applicable as no further Distinction Awards are made. Those in receipt of a Distinction Award continue to receive their award, subject to five-year review.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – PREVIOUS NATIONAL SCHEMES

	ENGLAND and WALES	SCOTLAND	NORTHERN IRELAND
Transparency	No further awards are made under this scheme. All current award holders appear in the published 'nominal roll' on the ACCEA website.	The names of successful applicants are published on the SACDA website.	Not applicable – no further awards are made under this scheme. The names of all Distinction Award holders are published in NICEAC's Annual Report which is also available on the DHSSPSNI website.
Criteria for selection	Not applicable – no further awards are made under this scheme.	Consultants must provide evidence about their performance in six domains : <ul style="list-style-type: none"> • 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. 	Not applicable – no further awards are made under this scheme.
Pensionability	All levels are pensionable.	All levels are pensionable.	All levels are pensionable.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – PREVIOUS NATIONAL SCHEMES

	ENGLAND and WALES	SCOTLAND	NORTHERN IRELAND
Retirement and partial retirement	<p>Distinction Award holders who retire and return to work within 12 months, and continue in the same or similar post, working to the level that they received their original award, and working at least four programmed activities, may apply to ACCEA for reinstatement of their award. Reinstated awards are subject to annual review. Failure to submit an annual review results in the withdrawal of the award.</p>	<p>Distinction Award holders who retire and take their NHS pension then return to work, and continue in the same specialty, are no longer able to retain their award.</p>	<p>All awards cease on retirement. There is no eligibility for payment of awards on re-employment after retirement. Prior to 2005, Distinction Award holders who retired and were re-employed in a substantive Health and Personal Social Services/NHS consultant post in the same specialty could be paid their Distinction Award where they continued to meet the criteria for holding an award.</p>

LOCAL SCHEMES

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – CURRENT LOCAL SCHEMES

	ENGLAND	WALES	SCOTLAND	NORTHERN IRELAND
CURRENT SCHEME³	Employer-based Clinical Excellence Awards.	There is no local scheme – Wales has a system of Commitment Awards which are paid automatically every three years after reaching the maximum of the pay scale.	Scottish Consultants' Clinical Leadership and Excellence Awards (SCCLEAs).	Clinical Excellence Awards.
Date scheme started	2003.	2003.	On hold pending DDRB review – new scheme was due to start in 2011.	2005.
Awarding body	Local employer's award committee.	Not applicable – paid every three years after reaching the maximum of the pay scale.	Local award committee, but Scottish Advisory Committee on Consultants' Clinical Leadership and Excellence Awards (SACCLEA) will have a monitoring role.	Local award committee in each Health and Social Care Trust.

³ In the case of Scotland, implementation of this scheme has been delayed pending the DDRB review.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – CURRENT LOCAL SCHEMES

	ENGLAND	WALES	SCOTLAND	NORTHERN IRELAND
Value of awards – 1 April 2011	Level 1 – £2,957	1st – £3,204	Not applicable as the scheme is on hold. However, it was intended that no additional funding would be available for the new scheme.	Step 1 – £2,957
<i>The award of a higher award subsumes the value of any previous award.</i>	Level 2 – £5,914	2nd – £6,408	Proposed rates for 2011:	Step 2 – £5,914
	Level 3 – £8,871	3rd – £9,612	Grade 1 – £3,204	Step 3 – £8,871
	Level 4 – £11,828	4th – £12,816	Grade 2 – £6,408	Step 4 – £11,828
	Level 5 – £14,785	5th – £16,020	Grade 3 – £9,612	Step 5 – £14,785
	Level 6 – £17,742	6th – £19,224	Grade 4 – £12,816	Step 6 – £17,742
	Level 7 – £23,656	7th – £22,428	Grade 5 – £16,020	Step 7 – £23,656
	Level 8 – £29,570	8th – £25,632	Grade 6 – £19,224	Step 8 – £29,570
	Level 9 – £35,484 (equal to a bronze award)	Value of awards uprated in line with DDRB recommendations (if accepted).	Grade 7 – £22,428	Value of awards uprated in line with DDRB recommendations (if accepted).
	Value of awards uprated in line with DDRB recommendations (if accepted).		Grade 8 – £25,632	
			Grade 9 – £28,830	
			Grade 10 – £32,033	
			Value of awards uprated in line with DDRB recommendations (if accepted).	

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – CURRENT LOCAL SCHEMES

	ENGLAND	WALES	SCOTLAND	NORTHERN IRELAND
Number of awards granted	No specific number of awards required, but funding must be available for at least the same investment as would have occurred under the previous system of Discretionary Points – minimum ratio of 0.35 awards per eligible consultant. Because of the different steps in the value of awards, this does not precisely determine the number of awards. For the 2011 round this ratio was reduced to 0.2.	As eligible through length of service.	Employers required to allocate a minimum of 0.35 awards per eligible consultant in relation to Grades 1 to 8. The exact funding arrangements for the new scheme have yet to be finalised.	Employers required to allocate a minimum of 0.25 awards per eligible consultant.
Budget for scheme	Budgets are determined locally according to the funding formula.	Generally based on previous year's spend plus inflation.	No additional money was to be made available to fund the awards. Grades 9 and 10 were to be funded from the retirements of 'B' award holders. The funding for Grades 1 to 8 would come out of the national allocation that each Board received from the government as before.	Funding for lower Clinical Excellence Awards is included in employers' baseline allocation of funding which is provided by the DHSSPSNI.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – CURRENT LOCAL SCHEMES				
	ENGLAND	WALES	SCOTLAND	
	WALES		NORTHERN IRELAND	
Advancement in scheme	Local award committees able to make awards which advance consultants by more than one level in one year. There is no fixed time limit that determines whether a consultant should be considered for advancement. Can apply for advancement each year if can demonstrate a step change. <i>Some employers have agreed variations with ACCEA.</i>	Every three years after reaching the maximum of the pay scale. There is no fixed time limit that determines whether a consultant should be considered for a bronze award, although it usually takes about ten years.	Local award committees permitted to make awards which advance consultants by more than one level in one year. There is no fixed time limit that determines whether a consultant should be considered for a national award, although it usually takes about ten years. Can apply for advancement each year if can demonstrate a step change.	Must have served at least three years as a consultant to apply for a step 1 lower Clinical Excellence Award. It is normal practice for consultants to move from one step to the next but trusts may exceptionally award more than one step in any year. It is not permitted to apply for a lower and higher award in the same year.
Review and renewal criteria	Level 9 awards are subject to five-yearly reviews. Otherwise awards are reviewed as determined by the employer.	Not applicable.	Local awards are not subject to review.	Reviewed every five years – more frequently where disciplinary or professional proceedings uphold concerns/allegations of conduct/performance.
Equality of opportunity	Awards are made on application by consultants, using ACCEA's standard form. Monitoring is carried out through annual reports and through analysis of data from the electronic staff record. The results are included in ACCEA's Annual Report.	Not applicable – paid every three years after reaching maximum on pay scale.	Self nomination.	Self nomination is the only method of application.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – CURRENT LOCAL SCHEMES

	ENGLAND	WALES	SCOTLAND	NORTHERN IRELAND
Current status of scheme	Open.	Commitment Awards are not affected by the pay freeze and are treated in the same way as increments.	Scheme frozen pending DDRB review – this is a new scheme which was due to be implemented in 2011.	DHSSPSNI took the decision that no new local awards should be made in 2010-11.
Eligibility	NHS consultants with at least one year's experience at consultant level. Academic general practitioners. Senior clinical academics who hold honorary NHS contracts. Postgraduate deans/heads of schools of medicine/dentistry. Consultants working as NHS trust clinical/medical directors or equivalent.	Every three years after reaching the maximum of the pay scale.	Consultants will normally be on the fifth point of the pay scale (five years) before being eligible for an award. NHS consultants, clinical academics and senior academic general practitioners.	Consultants who have served for three years. Subject to participation in appraisal and job plan; observance of private practice code of conduct; no adverse outcome from disciplinary proceedings. NB Clinical academic general practitioners are not eligible.
Transparency	As of 2010, ACCEA publishes local award holders in the Nominal Roll (available on the ACCEA website). This information is drawn from the NHS electronic staff record. Local trusts publish the names of awardees in the Employer-Based Awards Annual Report.	Not applicable.	Health Board local committees to publish the names. The SACCCLEA website to publish the nominal roll of consultants which lists every consultant in Scotland and their award. Consultants will be able to receive information on their individual scores and ranking on request.	Names of successful applicants are published in NICEAC's Annual Report which is also available on the DHSSPSNI website.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – CURRENT LOCAL SCHEMES			
	ENGLAND	WALES	SCOTLAND
			NORTHERN IRELAND
Criteria for selection	Consultants must provide evidence about their performance in the same five domains as for national awards.	Every three years after reaching the maximum of the pay scale.	Consultants must provide evidence about their performance in the same four criteria as for national awards.
Pensionability	All levels are pensionable.	All levels are pensionable.	All levels are pensionable.
Retirement and partial retirement	Awards cease to be paid from consultant's retirement date or date NHS pension is paid. Clinical Excellence Awards cannot be reinstated if a consultant returns to work after retirement.	Commitment Awards continue to be paid for those who retire and return.	All awards cease on retirement. There is no eligibility for payment of awards on re-employment after retirement.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – PREVIOUS LOCAL SCHEMES				
	ENGLAND	WALES	SCOTLAND	NORTHERN IRELAND
PREVIOUS SCHEME⁴ – awards remain payable to existing holders until the holder retires or gains a new award.	Discretionary Points.	Discretionary Points.	Discretionary Points.	Discretionary Points.
Date scheme started	1990.	1990.	1996 – revised 2000.	1996.
Awarding body	The relevant NHS employer.	The relevant NHS employer.	Individual Health Boards.	Local Health and Social Care Employers.
Value of awards – 1 April 2011	£3,204	Not applicable – all Discretionary Points holders in Wales have moved to Commitment Awards.	£3,204	£3,204
The award of a higher award subsumes the value of any previous award.	£6,408		£6,408	£6,408
	£9,612		£9,612	£9,612
	£12,816		£12,816	£12,816
	£16,020		£16,020	£16,020
	£19,224		£19,224	£19,224
	£22,428		£22,428	£22,428
	£25,632		£25,632	£25,632
	Value of awards uprated in line with DDRB recommendations (if accepted).		Value of awards uprated in line with DDRB recommendations (if accepted).	Value of awards uprated in line with DDRB recommendations (if accepted).
Number of awards granted	Not applicable – no further awards are made under this scheme.	Not applicable – no further awards are made under this scheme.	Employers required to allocate a minimum of 0.35 awards per eligible consultant.	Not applicable – no further awards made under this scheme.
Budget for scheme	Not applicable – no further awards made under this scheme.	Not applicable – no further awards made under this scheme.	No budget. The funding is met by Boards' annual base allocation from the government.	Not applicable – no further awards made under this scheme.

⁴ In the case of Scotland, this is effectively the current scheme (although frozen) as implementation of the new scheme has been delayed pending the DDRB review.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – PREVIOUS LOCAL SCHEMES			
	ENGLAND	WALES	SCOTLAND
	WALES		NORTHERN IRELAND
Advancement in scheme	No further awards made under this scheme; further awards made as local or national Clinical Excellence Awards.	No further awards made under this scheme; all Discretionary Points holders in Wales have moved to Commitment Awards. Further awards made as national Clinical Excellence Awards.	Normally expected to have ten years' experience at consultant grade in their discipline before applying for a B award.
Review and renewal criteria	Not applicable – no further awards are made under this scheme.	Not applicable – scheme closed.	No review process.
Equality of opportunity	Not applicable – no further awards are made under this scheme.	Not applicable – scheme closed.	Not applicable – no further awards are made under this scheme.
Current status of scheme	No further awards made under this scheme. Awards remain payable to existing holders until the holder retires or gains a new award.	Closed. All Discretionary Point holders in Wales have moved to Commitment Awards.	Scheme frozen pending DDRB review.
Eligibility	Not applicable – no further awards are made under this scheme.	Not applicable – scheme closed.	No further awards made under this scheme. Awards remain payable to existing holders until the holder retires or gains a new award.
			Not applicable – no further awards are made under this scheme.
			Consultants must be on the fifth point of the new pay scale (five years) before being eligible for an award.
			NHS consultants and clinical academics only.

MAIN FEATURES OF THE CONSULTANTS' AWARD SCHEMES ACROSS THE UNITED KINGDOM – PREVIOUS LOCAL SCHEMES

	ENGLAND	WALES	SCOTLAND	NORTHERN IRELAND
Transparency	Not applicable – no further awards are made under this scheme.	Not applicable – scheme closed.	SACDA publishes a nominal roll on its website listing the consultant population in Scotland which shows awards held by each consultant.	Not applicable – no further awards are made under this scheme.
Criteria for selection	Not applicable – no further awards are made under this scheme.	Not applicable – scheme closed.	Consultants expected to demonstrate an above average contribution in respect of one or more of: service to patients; teaching; research; and management and development of the service.	Not applicable – no further awards are made under this scheme.
Pensionability	All levels are pensionable.	All levels are pensionable.	All levels are pensionable.	All levels are pensionable.
Retirement and partial retirement	Discretionary Point holders who retire and return to work within 12 months, and continue in the same or similar post, working to the level that they received their original award, and working at least 4 programmed activities, can apply for reinstatement of their award. The decision to reinstate is at the discretion of the trust.	Not applicable – scheme closed.	Entitled to retain award on reinstatement.	All awards cease on retirement. There is no eligibility for payment of awards on re-employment after retirement.

APPENDIX F

COMPARABILITY OF CONSULTANTS' AWARD SCHEMES WITH OTHER CORE PUBLIC SECTOR AND NHS CONTINGENT PAY¹ SCHEMES

Excludes recruitment and retention premia and other allowances that are not performance/contribution/skill/experience related.

COMPARABILITY OF CONSULTANTS' AWARD SCHEMES WITH OTHER CORE PUBLIC SECTOR AND NHS CONTINGENT PAY SCHEMES

	Individual performance-related pay (merit pay) ²	Bonuses ³	Incentives ⁴	Incremental pay linked to performance ⁵	Competence-related pay ⁶	Contribution-related pay ⁷
Hospital doctors/dentists – DDRB remit group				<p>Pay structure based on incremental scale linked to length of service, subject to satisfactory performance.</p> <p>For consultants in Wales, Commitment Awards are paid every three years after reaching the maximum of the pay scale. There are a total of eight Commitment Awards – consolidated and pensionable. (In the rest of the United Kingdom these would be local Clinical Excellence Awards).</p>		<p>Clinical Excellence Awards/Distinction Awards for consultants. Clinical Excellence Awards are consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. All levels of Clinical Excellence Award are pensionable. Award of Distinction Awards in Scotland and previously in other United Kingdom countries.</p>

¹ *Contingent pay* – additional financial rewards that are related to performance, competence, skill and/or experience. Known as *variable pay* or *pay-at-risk* if the payments are not consolidated into base pay.

² *Individual performance-related pay* – increases in base pay or cash bonuses are determined by performance assessment and ratings.

³ *Bonuses* – rewards for successful performance paid as cash lump-sums related to the results obtained by individuals.

⁴ *Incentives* – payments linked with the achievement of previously-set targets which are designed to motivate people to achieve higher levels of performance; the targets are usually quantified in terms of output or sales.

⁵ *Incremental pay linked to performance* – increases by fixed increments on a scale or pay spine depending on service in the job; there may be scope for varying the rate of progress up the scale according to performance.

⁶ *Competence-related pay* – varies according to the level of competence achieved by the individual. Included in this category is skill-based pay (sometimes known as knowledge-based pay) which varies according to the level of skill the individual achieves.

⁷ *Contribution-related pay* – relates pay to both outputs (performance) and inputs (competence).

COMPARABILITY OF CONSULTANTS' AWARD SCHEMES WITH OTHER CORE PUBLIC SECTOR AND NHS CONTINGENT PAY SCHEMES

	Individual performance-related pay (merit pay) ²	Bonuses ³	Incentives ⁴	Incremental pay linked to performance ⁵	Competence-related pay ⁶	Contribution-related pay ⁷
General medical practitioners – DDRB remit group			Quality and Outcomes Framework (QOF) – points-based system. Payments are made under the General Medical Services contract for achieving various government priorities.			
General dental practitioners – DDRB remit group			Personal Dental Services Plus contract – at least 51% of contract payment is based on units of dental activity, maximum 20% on quality target agreed with primary care trust and the rest for access.			General Dental Services contract – payment based on units of dental activity. Personal Dental Services Plus contract – at least 51% of contract payment is based on units of dental activity, max. 20% on quality target agreed with primary care trust and the rest for access.
NHS Agenda for Change staff					Incremental scale – some time-related others through gateways linked to competence (Knowledge and Skills Framework). It was designed to facilitate career progression and provides an outline of	

COMPARABILITY OF CONSULTANTS' AWARD SCHEMES WITH OTHER CORE PUBLIC SECTOR AND NHS CONTINGENT PAY SCHEMES

Individual performance-related pay (merit pay) ²	Bonuses ³	Incentives ⁴	Incremental pay linked to performance ⁵	Competence-related pay ⁶	Contribution-related pay ⁷
<p>Annual uplift to base pay – performance determined by whether or not the organisation has met its financial targets. There are four levels of award (outstanding to not satisfactory). If an organisation does not achieve its financial targets, this counts as not satisfactory regardless of individual performance and no uplift in salary is paid⁹.</p>	<p>Bonus is non pensionable, one-off payment. Department of Health determines the ceiling for the bonus (e.g. 5% in 2009-10) and only the top 25% of performers are eligible to receive them. No bonus is payable if the organisation does not achieve its financial targets regardless of individual performance.¹⁰</p>			<p>the knowledge and skills necessary for each post. It has been criticised by both managers and staff for being over-bureaucratic and time-consuming and in consequence has been underused, which has led to a relaunch of the scheme.⁸</p>	<p>Up to a maximum of 10% of base salary may be paid for additional responsibilities – when Very Senior Managers take on additional responsibilities beyond those required in their roles. It may be pensionable and can also count towards the calculation of bonus pay.¹¹</p>

⁸ *Pay in the public services 2011: the challenge for reward*. Incomes Data Services, March 2011: 122-123.

⁹ Review Body on Senior Salaries. *Thirty-third report on senior salaries*. Cm 8026. TSO, 2011: para. 5.15. Available from: http://www.ome.uk.com/SSRB_Reports.aspx

¹⁰ Review Body on Senior Salaries. *Thirty-third report on senior salaries*. Cm 8026. TSO, 2011: para. 5.16. Available from: http://www.ome.uk.com/SSRB_Reports.aspx

¹¹ Review Body on Senior Salaries. *Thirty-third report on senior salaries*. Cm 8026. TSO, 2011: para. 5.18. Available from: http://www.ome.uk.com/SSRB_Reports.aspx

COMPARABILITY OF CONSULTANTS' AWARD SCHEMES WITH OTHER CORE PUBLIC SECTOR AND NHS CONTINGENT PAY SCHEMES

	Individual performance-related pay (merit pay) ²	Bonuses ³	Incentives ⁴	Incremental pay linked to performance ⁵	Competence-related pay ⁶	Contribution-related pay ⁷
Judges	The judiciary are paid a spot rate and receive no form of contingent pay as this is perceived to run counter to their constitutional position and judicial independence. A major review of judicial pay is held roughly every five years to reconsider the rates paid and the most recent review was published in March 2011. ¹²					
Members of Parliament	There is no contingent pay for Members of Parliament.					
Senior Civil Service – SSRB remit	Annual base pay increases and additional non-consolidated, non-pensionable payments subject to performance and target distribution. ¹³	Non-consolidated and non-pensionable payments to reward in-year performance against objectives. The best performers receive the highest amounts. Payments are limited to a maximum of 5% of pay bill and only the top 25% of performers are eligible to receive them. ¹⁴				
Central government (Civil Service)	Incremental scale linked to performance.	Non-consolidated bonuses are a feature of many Civil Service pay deals, but the amounts are normally relatively small, typically less than £500 for lower grades and up to £3,000 for higher grades. ¹⁵		Incremental scale linked to performance and length of service.		

¹² Review Body on Senior Salaries. *Thirty-third report on senior salaries*. Cm 8026. TSO, 2011: chapter 4. Available from: http://www.ome.uk.com/SSRB_Reports.aspx

¹³ Review Body on Senior Salaries. *Thirty-third report on senior salaries*. Cm 8026. TSO, 2011: paras. 2.6 and 2.8. Available from: http://www.ome.uk.com/SSRB_Reports.aspx

¹⁴ Review Body on Senior Salaries. *Thirty-third report on senior salaries*. Cm 8026. TSO, 2011: paras. 1.8 and 2.8. Available from: http://www.ome.uk.com/SSRB_Reports.aspx

¹⁵ *Pay in the public services: review of 2009, prospects for 2010*. Incomes Data Services, March 2010: 34-35.

COMPARABILITY OF CONSULTANTS' AWARD SCHEMES WITH OTHER CORE PUBLIC SECTOR AND NHS CONTINGENT PAY SCHEMES

	Individual performance-related pay (merit pay) ²	Bonuses ³	Incentives ⁴	Incremental pay linked to performance ⁵	Competence-related pay ⁶	Contribution-related pay ⁷
Armed Forces – AFPRB remit				Incremental scale linked to time, not performance.		Consultants in the Armed Forces have a similar system of Clinical Excellence Awards/Distinction Awards equivalent to the national awards in the NHS, but the values are lower than in the NHS: e.g. platinum £57,912, bronze £18,859 (2010). ¹⁶ Awards are not pensionable. ¹⁷ Number of awards increased to 38 in 2009 to match the proportion available in the NHS (13%). ¹⁸
Senior Officers in the Armed Forces – SSRB remit	Incremental scale linked to performance. ¹⁹			Incremental scale linked to performance.		
Prison Service		Managers/governors who exceed performance targets can qualify for non-consolidated bonuses.		Incremental scale for uniformed grades which is automatic. For managers/governors progression is based on performance.		

¹⁶ Armed Forces' Pay Review Body. *Service medical and dental officers. Supplement to the thirty-ninth report.* Cm 7838. TSO, 2010: 21. Available from: http://www.ome.uk.com/AFPRB_Reports.aspx

¹⁷ Armed Forces' Pay Review Body. *Service medical and dental officers. Supplement to the thirty-sixth report.* Cm 7066. TSO, 2007: para. 58. Available from: http://www.ome.uk.com/AFPRB_Reports.aspx

¹⁸ Armed Forces' Pay Review Body. *Service medical and dental officers. Supplement to the thirty-eighth report.* Cm 7569. TSO, 2009: para. 58. Available from: http://www.ome.uk.com/AFPRB_Reports.aspx

¹⁹ Review Body on Senior Salaries. *Thirty-third report on senior salaries.* Cm 8026. TSO, 2011: paras. 3.1.1-3.15. Available from: http://www.ome.uk.com/SSRB_Reports.aspx

COMPARABILITY OF CONSULTANTS' AWARD SCHEMES WITH OTHER CORE PUBLIC SECTOR AND NHS CONTINGENT PAY SCHEMES

	Individual performance-related pay (merit pay) ²	Bonuses ³	Incentives ⁴	Incremental pay linked to performance ⁵	Competence-related pay ⁶	Contribution-related pay ⁷
Teachers				<p>Incremental scale linked to length of service – automatic unless performance is unsatisfactory.</p> <p>Pay progression for Advanced Skills Teachers is subject to annual performance reviews.²⁰</p> <p>Increments are performance related in sixth-form colleges.²¹</p>	<p>Those who reach the top of the pay scale can apply for progression through the threshold to the upper pay scale.²² A teacher can only progress up this scale after two years, provided they have continued to make a substantial and sustained contribution to the school.</p> <p>Senior teachers who have been at point 3 (top) on the upper spine for a minimum of two years are eligible to apply for 'Excellent Teacher' status²³ (where an Excellent Teacher post has been created in the school). They are allocated a spot salary from a pay range for Excellent Teachers.</p>	<p>Teaching and Learning Responsibility payments and Special Educational Needs allowance payable to those teachers with additional relevant responsibilities. Separate leadership pay spine.</p>

²⁰ Pay in the public services: review of 2009, prospects for 2010. Incomes Data Services, March 2010: 171.

²¹ Pay in the public services: review of 2009, prospects for 2010. Incomes Data Services, March 2010: 176.

²² Pay in the public services: review of 2009, prospects for 2010. Incomes Data Services, March 2010: 162.

²³ Pay in the public services 2011: the challenge for reward. Incomes Data Services, March 2011: 144.

COMPARABILITY OF CONSULTANTS' AWARD SCHEMES WITH OTHER CORE PUBLIC SECTOR AND NHS CONTINGENT PAY SCHEMES

Individual performance-related pay (merit pay) ²	Bonuses ³	Incentives ⁴	Incremental pay linked to performance ⁵	Competence-related pay ⁶	Contribution-related pay ⁷
<p>For superintendents, chief superintendents, assistant chief constables and commanders, incremental progression is based on performance development review rating. Single increment for competency, double for exceptional performance.</p>	<p>Association of Chief Police Officers rank officers are eligible for non-pensionable performance-related bonuses of up to 15% of salary for chief constables, 12.5% for deputy chief constables and 10% for assistant chief constables and commanders (at the performance.</p>		<p>Incremental scale linked to length of service.²⁷</p>	<p>Officers who have been at the top of the scale for a year are eligible for pensionable Competence Related Threshold Payments, £1,212 a year in 2010 (introduced 2002).</p>	<p>Special Priority Payments are an extra reward for posts that carry significantly higher responsibility than the norm for that rank (or present particular recruitment and retention difficulties or have especially demanding working conditions/</p>
<p>Police²⁶</p>				<p>Separate pay spine for Advanced Skills Teachers who act as mentors to other teachers and are expected to spend 20% of their time spreading good practice in other schools.²⁴</p> <p>Professional standards payment scheme in sixth-form colleges (similar to performance threshold for school teachers).²⁵</p>	

²⁴ Pay in the public services: review of 2009, prospects for 2010. Incomes Data Services, March 2010: 171.

²⁵ Pay in the public services: review of 2009, prospects for 2010. Incomes Data Services, March 2010: 176.

²⁶ The 'Winsor Review' has recommended a number of changes to police pay. See: *Independent review of police officer and staff remuneration and conditions: part 1. Report. Cm 8024. TSO, March 2011.* Available from: <http://review.police.uk/documents/police-remun-and-conditions/first-report?view=Binary>

²⁷ Pay in the public services 2011: the challenge for reward. Incomes Data Services, March 2011: 111.

COMPARABILITY OF CONSULTANTS' AWARD SCHEMES WITH OTHER CORE PUBLIC SECTOR AND NHS CONTINGENT PAY SCHEMES

	Individual performance-related pay (merit pay)²	Bonuses³	Incentives⁴	Incremental pay linked to performance⁵	Competence-related pay⁶	Contribution-related pay⁷
		<p>top of the pay scale). Superintendents and chief superintendents who have been at the top of their pay scale for at least a year and who are rated as exceptional in their performance development review are eligible for non-pensionable bonus of 5% of pensionable pay.</p>				<p>environments). Payments range between £500 and £3,000, or up to £5,000 in exceptional circumstances. Limited to 40% of the workforce in the majority of forces. Non-pensionable and paid as one-off lump sum.</p>
Local Government		<p>16% of senior executives are eligible for bonus payments.²⁸</p>		<p>Incremental scales – may differ slightly depending on whether councils are opted in or out of National Joint Council salary scales, or United Kingdom country.²⁹ Increments tend not to be performance-linked, except for senior staff not on the National Joint Council scales.</p>		

²⁸ Information from Incomes Data Services.

²⁹ *Pay in the public services 2011: the challenge for reward*. Incomes Data Services, March 2011: chapter 2.

COMPARABILITY OF CONSULTANTS' AWARD SCHEMES WITH OTHER CORE PUBLIC SECTOR AND NHS CONTINGENT PAY SCHEMES

	Individual performance-related pay (merit pay) ²	Bonuses ³	Incentives ⁴	Incremental pay linked to performance ⁵	Competence-related pay ⁶	Contribution-related pay ⁷
Fire Service					<p>Pay structure for fire fighting roles has trainee, development and competent A/B levels. Pay structure is linked to the Integrated Personal Development System which compares skills to national occupational standards and National Vocational Qualifications required for the role.³⁰</p> <p>Continual Professional Development payment is an experience and knowledge-based payment. To qualify for payment, must demonstrate continuing professional development above that required at 'competent' level. Payments varied between £207 in Highlands and £949 in South Yorkshire in 2011.³¹ (Replaced Long Service Increment in 2007.)</p>	

³⁰ Pay in the public services: review of 2009, prospects for 2010. Incomes Data Services, March 2010: 132.

³¹ Pay in the public services 2011: the challenge for reward. Incomes Data Services, March 2011: 107.

COMPARABILITY OF CONSULTANTS' AWARD SCHEMES WITH OTHER CORE PUBLIC SECTOR AND NHS CONTINGENT PAY SCHEMES

	Individual performance-related pay (merit pay) ²	Bonuses ³	Incentives ⁴	Incremental pay linked to performance ⁵	Competence-related pay ⁶	Contribution-related pay ⁷
Further Education Colleges				Incremental scale. In England harmonised pay spine for support staff, lecturers and management. ³² In Northern Ireland progression is time-related, though subject to satisfactory performance. ³³ In Wales incremental progression is time-related, but subject to satisfactory performance. ³⁴	In Northern Ireland, progression to threshold point after reaching top of scale is based on performance. ³⁵ In Wales there is an upper pay scale for lecturers. ³⁶	
Universities				Increments for support staff and academic staff. ³⁷	Accelerated progression for academic staff. ³⁸	Three incremental contribution pay points for academic staff at the top of each grade. ³⁹

³² Pay in the public services: review of 2009, prospects for 2010. Incomes Data Services, March 2010: 196.

³³ Pay in the public services: review of 2009, prospects for 2010. Incomes Data Services, March 2010: 199.

³⁴ Pay in the public services: review of 2009, prospects for 2010. Incomes Data Services, March 2010: 200.

³⁵ Pay in the public services: review of 2009, prospects for 2010. Incomes Data Services, March 2010: 199.

³⁶ Pay in the public services: review of 2009, prospects for 2010. Incomes Data Services, March 2010: 200.

³⁷ Pay in the public services: review of 2009, prospects for 2010. Incomes Data Services, March 2010: 182.

³⁸ Pay in the public services: review of 2009, prospects for 2010. Incomes Data Services, March 2010: 182.

³⁹ Pay in the public services: review of 2009, prospects for 2010. Incomes Data Services, March 2010: 182, 203.

Sources of reference

Definitions from: Armstrong, Michael. *Employee reward*. 3rd ed. Chartered Institute of Personnel and Development, 2002.

APPENDIX G

PREVIOUS REPORTS BY THE REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

1971	Cmnd. 4825, December 1971
1972	Cmnd. 5010, June 1972
Third Report (1973)	Cmnd. 5353, July 1973
Supplement to Third Report (1973)	Cmnd. 5377, July 1973
Second Supplement to Third Report (1973)	Cmnd. 5517, December 1973
Fourth Report (1974)	Cmnd. 5644, June 1974
Supplement to Fourth Report (1974)	Cmnd. 5489, December 1974
Fifth Report (1975)	Cmnd. 6032, April 1975
Supplement to Fifth Report (1975)	Cmnd. 6243, September 1975
Second Supplement to Fifth Report (1975)	Cmnd. 6306, January 1976
Third Supplement to Fifth Report (1975)	Cmnd. 6406, February 1976
Sixth Report (1976)	Cmnd. 6473, May 1976
Seventh Report (1977)	Cmnd. 6800, May 1977
Eighth Report (1978)	Cmnd. 7176, May 1978
Ninth Report (1979)	Cmnd. 7574, June 1979
Supplement to Ninth Report (1979)	Cmnd. 7723, October 1979
Second Supplement to Ninth Report (1979)	Cmnd. 7790, December 1979
Tenth Report (1980)	Cmnd. 7903, May 1980
Eleventh Report (1981)	Cmnd. 8239, May 1981
Twelfth Report (1982)	Cmnd. 8550, May 1982
Thirteenth Report (1983)	Cmnd. 8878, May 1983
Fourteenth Report (1984)	Cmnd. 9256, June 1984
Fifteenth Report (1985)	Cmnd. 9527, June 1985
Sixteenth Report (1986)	Cmnd. 9788, May 1986
Seventeenth Report (1987)	Cm 127, April 1987
Supplement to Seventeenth Report (1987)	Cm 309, February 1988
Eighteenth Report (1988)	Cm 358, April 1988
Nineteenth Report (1989)	Cm 580, February 1989
Twentieth Report (1990)	Cm 937, February 1990
Twenty-First Report (1991)	Cm 1412, January 1991
Supplement to Twenty-First Report (1991)	Cm 1632, September 1991
Second Supplement to Twenty-First Report (1991)	Cm 1759, December 1991
Twenty-Second Report (1992)	Cm 1813, February 1992
Twenty-Third Report (1994)	Cm 2460, February 1994
Twenty-Fourth Report (1995)	Cm 2760, February 1995
Supplement to Twenty-Fourth Report (1995)	Cm 2831, April 1995
Twenty-Fifth Report (1996)	Cm 3090, February 1996
Twenty-Sixth Report (1997)	Cm 3535, February 1997
Twenty-Seventh Report (1998)	Cm 3835, January 1998
Twenty-Eighth Report (1999)	Cm 4243, February 1999
Twenty-Ninth Report (2000)	Cm 4562, January 2000
Thirtieth Report (2001)	Cm 4998, December 2000

Supplement to Thirtieth Report (2001)	Cm 4999, February 2001
Thirty-First Report (2002)	Cm 5340, December 2001
Supplement to Thirty-First Report (2002)	Cm 5341, December 2001
Thirty-Second Report (2003)	Cm 5721, May 2003
Supplement to Thirty-Second Report (2003)	Cm 5722, June 2003
Thirty-Third Report (2004)	Cm 6127, March 2004
Thirty-Fourth Report (2005)	Cm 6463, February 2005
Thirty-Fifth Report (2006)	Cm 6733, March 2006
Thirty-Sixth Report (2007)	Cm 7025, March 2007
Thirty-Seventh Report (2008)	Cm 7327, April 2008
Thirty-Eighth Report (2009)	Cm 7579, March 2009
Thirty-Ninth Report (2010)	Cm 7837, March 2010

APPENDIX H

GLOSSARY OF TERMS

AGENDA FOR CHANGE – is the harmonised pay system in operation for the NHS. It applies to all directly-employed NHS staff with the exception of doctors, dentists and some Very Senior Managers.

AWARDS/AWARD SCHEMES – is the generic term used throughout the report to include Clinical Excellence Awards, Distinction Awards and Discretionary Points.

BASE/BASIC PAY – the annual rate of salary without any allowances or additional payments.

BONUS – rewards for successful performance paid as cash (lump) sums related to the results obtained by individuals, teams or business performance; they are not consolidated into basic pay.

CLINICAL ACADEMICS – doctors or dentists who are employed by Higher Education Institutions, or other organisations, in a research and/or teaching capacity and who also provide services for NHS patients. The group is comprised of consultant clinical academics and senior academic general medical practitioners holding honorary NHS contracts.

CLINICAL EXCELLENCE AWARDS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. All levels of Clinical Excellence Awards are pensionable.

COMMITMENT AWARDS – for consultants in Wales, Commitment Awards are paid every three years after reaching the maximum of the pay scale. There are a total of eight Commitment Awards. Commitment Awards replaced Discretionary Points in October 2003.

COMPETENCE-RELATED PAY – varies according to the level of competence/skill achieved by the individual. It is a method of rewarding people for their ability in their present and future roles, and is particularly appropriate for knowledge workers and professional staff where skills and behaviours are important. See also *skill-based pay*.

CONSOLIDATED PAY – an increase that is added to basic pay. Typically, consolidated pay is pensionable.

CONSULTANTS – the most senior medical and dental staff in the NHS. They have expert knowledge of their specialties, work either independently or as part of a team, and lead the delivery of NHS services.

CONTINGENT PAY – financial rewards in addition to base pay that are related to performance, competence, skill and/or experience. Contingent pay is often referred to as variable pay or pay-at-risk if the payments are not consolidated into base pay. The term 'performance-related pay' is frequently used synonymously in the literature where contingent pay is related to performance.

CONTRIBUTION-RELATED PAY – relates pay to both outputs (performance) and inputs (competence). It is concerned with how results are achieved as well as the results themselves and means paying for results plus competence and past performance as well as future success; Clinical Excellence Awards, Distinction Awards and Discretionary Points are a form of contribution-related pay.

DISCRETIONARY POINTS – now replaced by Clinical Excellence Awards in England and Northern Ireland, Commitment Awards in Wales, and Scottish Consultants Clinical Leadership and Excellence Awards. They remain payable to existing holders until the holder retires or gains a new award. All levels of Discretionary Points are pensionable.

DISTINCTION AWARDS – now replaced by national Clinical Excellence Awards in England, Wales and Northern Ireland, and Scottish Consultants Clinical Leadership and Excellence Awards. They remain payable to existing holders until the holder retires or gains a new award. All levels of Distinction Awards are pensionable.

HOSPITAL AND COMMUNITY HEALTH SERVICES STAFF – consultants; doctors and dentists in training; specialty doctors and associate specialists; and others (including: hospital practitioners; clinical assistants; and some public health and community medical and dental staff). General medical practitioners, general dental practitioners and ophthalmic medical practitioners are excluded from this category.

INCENTIVES – payments linked to the achievement of previously set targets that are designed to motivate people to achieve higher levels of performance; the targets are usually quantified in terms of output (for example, piecework) or sales.

INCREMENTS – see *service-related pay*.

JOB PLANNING – an agreement that sets out a consultant's duties, responsibilities and objectives for the coming year. In most cases, it will build upon the consultant's existing NHS commitments.

KNOWLEDGE-BASED PAY – see *skill-based pay*.

NHS VERY SENIOR MANAGERS – in England are chief executives, executive directors (except medical directors), and other senior managers with board level responsibility who report directly to the chief executive, in: Strategic Health Authorities, Special Health Authorities, Primary Care Trusts and Ambulance Trusts.

NON-CONSOLIDATED PAY – is not part of basic pay and is typically non-pensionable. Usually this is paid as a single payment, for example a lump sum.

NON-FINANCIAL INCENTIVES – an encouragement to employees to work harder or better that does not take the form of money; for example, company cars, paid sabbaticals.

PERFORMANCE-RELATED PAY – increases in base pay and/or cash bonuses are determined by performance assessment and ratings.

PROGRAMMED ACTIVITIES – under their new contract, consultants have to agree the number of Programmed Activities they will work. Each Programmed Activity is four hours, or three hours in 'premium time', which is defined as between 7 p.m. and 7 a.m. during the week, or any time at weekends. In England, Scotland and Northern Ireland, ten Programmed Activities represent a full-time post, but the contract refers only to minimum commitments and does not define a maximum. On average, 7.5 Programmed Activities are for direct clinical care and 2.5 are **Supporting Professional Activities**, for example, training, continuing professional development, job planning, appraisal and research, although different patterns can be agreed through the job planning process.

RECRUITMENT AND RETENTION PREMIA FOR CONSULTANTS – may be paid in addition to basic salary, either as a single sum, or for a time-limited period of no more than four years. The value of the premium will not typically exceed 30 per cent of the normal starting salary for a consultant post.

SCOTTISH CONSULTANTS CLINICAL LEADERSHIP AND EXCELLENCE AWARDS – a new scheme that was intended to replace Distinction Awards and Discretionary Points from 2011. The scheme is currently on hold pending the outcome of this review.

SERVICE-RELATED PAY (INCREMENTS) – increases by fixed increments on a scale or pay spine depending on service in the job; there may be scope for varying the rate of progress up the scale according to performance.

SKILL-BASED PAY – (sometimes known as knowledge-based pay) varies according to the level of skill the individual achieves. It was originally used in manufacturing firms but is now used in other service industries and is the equivalent of competence-related pay in these sectors. See also *competence-related pay*.

SUPPORTING PROFESSIONAL ACTIVITIES – see *Programmed Activities*.

TOTAL CASH – is comprised of basic pay plus short-term variable rewards, for example, bonuses or annual incentives. See also *basic pay*.

TOTAL DIRECT COMPENSATION – is comprised of total cash plus long-term rewards or incentives. See also *total cash*.

TOTAL REMUNERATION – is comprised of total direct compensation plus active and passive benefits. Active benefits include tangible benefits such as cars, professional memberships and discounts; passive benefits incorporate pensions and holiday pay. See also *total direct compensation*.

TOTAL REWARD – incorporates the total remuneration package (total cash plus total direct compensation) plus engagement factors (for example, quality of life, work-life balance, inspiration and values, enabling environment, growth and opportunity) which contribute to internal value or motivation. See also total remuneration, total cash, total direct compensation.

VERY SENIOR MANAGERS – see *NHS Very Senior Managers*.

APPENDIX I

ABBREVIATIONS AND ACRONYMS

ACCEA	Advisory Committee on Clinical Excellence Awards
ACDA	Advisory Committee on Distinction Awards
AFPRB	Armed Forces' Pay Review Body
CEA	Clinical Excellence Award
CPI	Consumer Prices Index
DDRB	Review Body on Doctors' and Dentists' Remuneration
DHSSPSNI	Department of Health, Social Services and Public Safety in Northern Ireland
FTE	Full-time equivalent
HCHS	Hospital and Community Health Services
HIV	Human Immunodeficiency Virus
ISD	Information Services Division
NHS	National Health Service
NHSPRB	NHS Pay Review Body
NI	National Insurance
NICEAC	Northern Ireland Clinical Excellence Awards Committee
RPI	Retail Prices Index
SACCCLEA	Scottish Advisory Committee on Consultants' Clinical Leadership and Excellence Awards
SACDA	Scottish Advisory Committee on Distinction Awards
SCCLEA	Scottish Consultants Clinical Leadership and Excellence Awards
SGHD	Scottish Government Health Department
SSRB	Review Body on Senior Salaries
UK	United Kingdom
WAG	Welsh Assembly Government



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