

CLINICAL EXCELLENCE AWARDS

Academy of Medical Royal Colleges submission to the Review Body on Doctors' and Dentists' Remuneration

Introduction

The Academy of Medical Royal Colleges (the Academy) welcomes the opportunity to make a submission to the review of Clinical Excellence Awards (CEAs) being conducted for the Government by the Doctors and Dentists Review Body (DDRB).

The Academy represents the Medical Royal Colleges and Faculties across the UK. The Academy's role is to promote, facilitate and where appropriate co-ordinate the work of the Medical Royal Colleges and their Faculties for the benefit of patients and healthcare. The main work of Colleges and Faculties concerns post-graduate medical education and standards of clinical practice.

The Academy itself is a nominating body for platinum awards and its chairman is a member of the Advisory Committee on Clinical Excellence Awards (ACCEA). Individual Colleges and Faculties are able to make nominations for other national awards.

The Academy and Colleges do not have a role in employment, pay, or terms and conditions issues. Therefore careful consideration was given as to whether the Academy should make a submission to the review of CEAs. It was, however, considered that an Academy view should be put forward because of the important contribution it believes that CEAs make to quality and excellence to the NHS as a whole.

Scope of submission

The Academy's submission will concentrate mainly on two parts of the review's terms of reference namely the need "*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*" and, secondly, "*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.*"

Accordingly, this submission concentrates primarily on the national level awards rather than employer level awards. Equally it is not the role of the Academy to comment on basic pay scales for doctors.

National Clinical Excellence Awards Scheme

The purpose of national awards

In the White Paper *Liberating the NHS* the Government has clearly stated its commitment to the concept of a national health service free at the point of use and available to everyone based on need, not ability to pay. Whilst the Government envisages greater autonomy for individual healthcare providers it sees them operating within a national framework and a national set of principles that are currently defined by the NHS Constitution.

In a system with greater local organisational autonomy the question of how to reward and incentivise contributions to the wider NHS becomes more, not less, pertinent.

The Academy strongly believes that national level awards must be there to recognise exceptional contributions to the wider NHS and reward doctors for their input into the development of the health system in the UK as a whole beyond the level of the provision of care and services at a local level.

The Academy believes that recognition of such work is essential to:

- **Reward** excellence in achievement for the wider NHS
- **Incentivise** involvement and continuation in activity contributing to improvement of the wider NHS
- Support the **retention** of national/international expertise within the UK health service.

Reward

As the scheme states, its purpose is to “*reward individuals who achieve over and above the standard expected of a consultant or academic GP in their post.*” Contributions to the wider NHS will, almost by definition, be beyond the scope of what is expected by a consultant in his or her post.

At present, 11% of consultants receive national awards recognising their contribution to the wider NHS beyond their local employer level. Whilst there can be no objective measure of the appropriateness of the figure, this proportion of senior doctors recognised for high quality contributions to the wider health system seems neither unreasonable nor unexpected.

The level of national awards is, of course, not insignificant. But they are possibly misleadingly high as they incorporate employer level awards. ACCEA reports that over 80% of those receiving a bronze award for the first time were already in receipt of local awards at level 5 or above which in effect reduces the size of the national “reward” by about £20,000 on average. Seen in this context the Academy does not believe that the reward for national or international medical excellence of between £15,000 and £55,000 is excessive.

Incentive

The Academy also believes that national CEAs provide an important incentive for doctors initially to become involved, and as important, to remain involved in work for the wider NHS. The Academy and Colleges are very aware that CEAs have a major motivational effect on doctors, encouraging them to strive for excellence.

The Academy would argue that NHS and UK medicine depends on the participation and contribution of doctors to the wider NHS, beyond their own Trust, not only for its development but also for its practical functioning. For example, the roles of senior doctors in the development of NICE guidelines, developing and updating the 58 specialty curricula, setting and applying professional standards through College exams, setting clinical

standards or reviewing and conducting clinical research all underpin the day to day operation of the NHS. Such work is vital to the future of healthcare in England but would not be regarded as a priority by all Trusts.

Without the contribution of medical, and other, staff, beyond the bounds of their local employer, the NHS would cease to function effectively. The reasons why individuals become involved in wider work will be a mixture of altruism, personal interest and career development. Whilst the original motive is rarely purely financial we do believe incentive to become and, importantly, to remain involved in work for the wider NHS is important and that reward is appropriate.

Successive Government's have stressed the importance of clinical engagement and leadership. The CEA scheme recognition of the importance of non-clinical roles in leadership, education and health policy making and planning is important both as a signal and an incentive for medical involvement in these areas.

Academic medicine

The Academy believes it is essential to maintain and improve recruitment into academic medicine and problems in this area are well known. Clinical academics are discouraged from private practice as it distracts from and competes with time for research/teaching. Therefore, awards provide 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.

There is a particular problem with recruitment into academic general practice. Only one in 225 general practitioners (GPs) in the UK are clinical academics compared to approximately one in 16 consultants in all hospital specialities, and the current number of academic general practice training posts is insufficient to sustain existing capacity. Full time academic GPs also earn about £30,000 less than full time service colleagues, if CEAs were withdrawn, it is likely to cause recruitment problems. With the significance of primary care and GP commissioning in the White Paper, having an academic primary care evidence base to underpin commissioning decisions is crucial.

Retention

It is important that the NHS keeps its highest calibre medical staff and that the UK health system retains doctors who are world class clinicians, leaders, researchers and teachers.

Medicine is, without doubt, a global employment market. International comparison of doctors' salaries or earnings is hugely difficult because of the widely varying methods and make up of remuneration in different countries. Therefore, figures presented here are not to be taken as hard data but more as indicative figures.

The Academy is not arguing that doctors are poorly rewarded per se. It acknowledges that UK doctors certainly fare well in comparison to their European counterparts. However, in the key English-speaking health markets of the USA and Australia the potential remains for UK doctors to obtain significantly higher earnings.

In Australia doctors current basic earnings range from £91-182,000, with expected overtime from £109-212,000 and with complete packages from £121-242,000 (*Source: International Medical Recruitment www.imrmedical.com/australiasalaries.htm*)

In the USA there is huge variation with median earnings ranging from £118,000 in geriatric medicine to £434,000 in spinal orthopaedic surgery. Within this range are, for example, Psychiatry at £135,000, Emergency Care at £168,000, Anaesthetics at £233,000, Cardiology

at £253,000, Vascular Surgery at £261,000, Interventional Diagnostic Radiology at £301,000 and Neurological Surgery at £372,000.

(Source: American Medical Group Association

www.cejkasearch.com/compensation/amga_physician_compensation_survey.htm)

Without, as stated, seeking to make direct comparisons (and recognising the potential in parts, but not all, of the UK for additional private earnings for doctors in some specialties) in all cases US earnings are above the top point of the UK consultant pay scale salary.

For professional and family reasons, most UK consultants are not actively seeking to work overseas. However, it is important that the UK health system recognises the potential for the loss of national expertise and is seen to acknowledge and address the issue in practical terms. The Academy believes that national Clinical Excellence Awards do seek to address this issue. But, possibly more importantly, they are perceived by doctors as being an acknowledgement of both national contribution and international worth. This psychological recognition may be as important as the precise cash value of any award.

The danger of losing high performers is greatest in academic, educational and research posts since it is in these fields that there is greatest movement between countries. The Academy believes that any serious erosion of the availability of national awards would risk triggering the loss of national medical excellence overseas.

Employer Level awards

The Academy believes that some but not all of the same arguments apply to employer level awards.

The scheme makes clear that awards are there to *“reward individuals who achieve over and above the standard expected of a consultant or academic GP in their post.”* It sets out what characteristics are required to be demonstrated. This was expanded in the advice sent to ACCEA from the National Quality Board by Sir David Nicholson in June 2009 and August 2010. The Academy considers that these characteristics are broadly correct.

The Academy believes that it is right that there is the opportunity to acknowledge and reward exceptional contribution by consultants and recognises that this contribution must relate to the objectives of the local organisation. Domains 1-3 covering the delivery, development and leadership of a high quality services rightly focus on services for patients. The Academy also strongly believes that Domains 4 and 5 covering research and education and training are equally important. These activities do need to be recognised by employers as a vital component of maintaining and improving the quality of care at a local level. It is important that excellence in these areas is not overlooked in the local awards.

Employer level awards give the opportunity for recognition of excellence in smaller hospitals where there may be less opportunity for clinicians to participate in national initiatives and/or research.

Employer level awards are given to 43% of all consultants. It is reasonable to consider whether that proportion of the consultant workforce receiving excellence awards is correct. It will, though, be difficult to make any objective judgement as to what a “correct” proportion might be. It is worth noting that over half of those local awards (54%) are levels 1-4 which equates to a performance bonus under £9,000.

Figure 1: Awards distribution England only August 2010

Type of award	Number	% of all awards	% of all consultants**
National	3917*	19.7	10.6
Local	15992	80.3	43.3
Total awards	19909	100	53.8
No awards	16950	-	45.9

* Removal of 231 consultants in Wales from ACCEA figures

** Total consultant workforce figure of 36,950 as at March 2010 (information Centre).

This results in a minor discrepancy from total sum above.

In more general terms it is vital that medicine remains an attractive and rewarding career option for young people making their university choices particularly with the likelihood of significantly increased costs for undergraduate medical education.

Operation and application of the system

Criteria

One of the strengths of the system is that it does encompass all possible aspects of medical practice such as education, research, leadership and contribution to policy making and therefore incorporates the whole profession including those who do not have a primarily clinical focus. The Academy therefore supports the criteria set out for the scheme and believes the five domains are correct.

National level awards are particularly relevant for outstanding work in Domains 3 (leadership), 4 (research and innovation) and 5 (teaching and training) although developing high quality services (Domain 2) can also have significant national implications. The Academy welcomes the emphasis on quality and leadership advised by the National Quality Board. Equally the Academy would not wish to see any dilution of recognition of the importance of research, training and education.

Operation

The Academy believes that there has been a vast improvement in the operation and application of the system at local and national level over recent years and welcomes this change.

The Academy considers that criticisms that the scheme is divisive, besides being self-evident, miss the point. Any scheme rewarding excellence on a competitive rather than a universal basis creates a division between those with and those without the reward. Equally, if the scheme is genuinely intended to reward excellence "*over and above the standard expected*" all doctors are not going to meet this criteria.

Accepting the concept of a scheme based on merit and competition it is, however, obviously important to ensure that it operates fairly. Whilst historically it may not always have been the case, the Academy believes that the system currently operates in an extremely fair and efficient manner.

We believe the criteria for awards are right and that at local and national level great efforts are made to follow these and operate the system effectively. Our experience is that the process for national awards is rigorous and robust. We also believe that local awards committees equally follow the processes and strive to link awards to quality of services and organisational goals.

Two of the key principles for the 2003 scheme were that it should be:

- Transparent, fair and based on clear evidence and perceived to be so both by the public and the profession
- Open and accessible to all eligible consultants.

The Academy believes that these have generally been met. The useful analyses undertaken by ACCEA of the gender and ethnic distribution of awards seem to show there is no statistically significant gender bias nor any real difference in the ratio of applications to awards between black and minority ethnic and white applicants (except in the case of Gold Awards).

Review

The Academy fully supports the principle that awards should be reviewed on a regular basis and that recipients should have to demonstrate that they continue to meet the criteria for receiving the award. Equally 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. Such rigor should apply to both national and local awards.

Conclusion

The Academy strongly believes that awards for excellence for consultants continue to be relevant and justifiable at both local and national level.

November 2010.