CONSULTATION ON THE NORTHERN IRELAND CLINICAL EXCELLENCE AWARDS SCHEME 2012/13 AND 2013/14

Outcome of Consultation and Departmental Response

Background

1. In the context of an exceptionally challenging financial situation, the Department of Health, Social Services and Public Safety (the Department) has been considering the operation of the Clinical Excellence Awards (CEA) Scheme in Northern Ireland.

2. Respondents to the consultation were aware that no new awards were made during the period of the public sector pay freeze of 2010/11 and 2011/12, on the basis that CEAs were deemed to be part of pay. For the 2012/13 CEA round, applications for new awards were invited in October 2013, based on the premise that no new monies would be required for these awards. The award of the CEAs however, did not proceed as anticipated as the financial position within the Health and Social Care sector (HSC) in Northern Ireland substantially changed between the initial decision in October 2013 and the date of the final recommendations in May 2014.

3. As a consequence, in December 2014, the Department launched a consultation with relevant stakeholders on the options for the 2012/13 and 2013/14 awards rounds. This included employers in the (HSC); HSC bodies; and the British Medical Association (BMA). The consultation ran for 8 weeks and closed on 16th February 2015. This report provides an analysis of the consultation and the Department’s response.
4. The two options outlined in the consultation were:

- **Option 1** - Allocate new CEAs in the normal manner for the 2012/13 and 2013/14 years; or
- **Option 2** - Allocate no new CEAs for the 2012/13 and 2013/14 years.

**Consultation feedback**

5. In total 76 responses were received, categorised as follows:

**Option 1 - 68 responses [89%]**
- 4 from representative bodies of the medical profession
- 2 employers
- 1 political party
- 61 consultants

**Option 2 - 6 responses [8%]**
- 5 consultants
- 1 private individual

**No option selected - 2 responses [3%]**
- 1 representative body
- 1 employer
Analysis of responses

6. Given that 74 of the responses were from members of, or representative bodies for, the medical profession, the preferred choice is not unexpected. Out of the 1,522 consultants in Northern Ireland at the time of the consultation only 4% responded. Comments under each of the options are paraphrased below and give a flavour of the views being expressed.

Arguments in support of Option 1

7. Arguments put forward included:
   - CEAs should award those that go ‘above and beyond’ their contractual duties/job plan.
   - Lack of CEAs will lead to an increasing reluctance to take on extra duties and responsibilities which are important for the development and improvement in education, research and high quality healthcare.
   - Lack of financial parity with the rest of the UK will have an adverse effect on retention and recruitment of quality staff.
   - Potential for discrimination against females – high volume of female consultants now entering the profession.
   - Potential for discrimination against younger consultants, especially those appointed after 2006/07.
   - Low morale if CEAs are not awarded.
   - CEAs are part of the agreed pay as per the current consultant contract.
   - Not paying CEAs could lead to the development of a two tier consultant system – those who have benefitted from the CEAs and those who have not.
   - Not paying CEAs will mean there is a lack of incentive for consultants to pursue excellence leading to a loss of innovation.
Arguments in support of Option 2

8. Arguments put forward included:
   - The current system is unequal and unfair. The whole system needs to be reviewed before awards are reinstated.
   - It is a ‘Corrupt system’ – consultants are receiving awards ‘in perpetuity’ for long since past work.
   - Scarce funds should be diverted to frontline services.
   - The delivery of quality care to patients and the improvement of the health and social care system is not something that should warrant additional reward in the form of extra money.
   - Monies should be used to fund direct patient care, appointing Specialty Doctors or Advance Nurse Practitioners. Funding should be directed to the entire team, not just the consultant.

The Department’s Position

9. The Department recognises the strong support that exists, from within the profession, for the CEA scheme to continue and is cognisant of the arguments put forward both in support and in opposition to it. The Department is also aware that the Doctors and Dentists Pay Review Body (DDRB) published a review of the process in December 2012, ‘Review of compensation levels, incentives and the clinical excellence and distinction awards scheme for Consultants in the NHS’. The Department welcomed this review and is fully committed to incentivising excellence and rewarding high performance. It is also fully engaged with BMA and NHS Employers in a process to develop a more effective and affordable mechanism for rewarding excellence as part of the work to develop a new contract for consultants. In November 2014, the Department invited the DDRB to provide observations on pay-related proposals
for reforming the consultants’ contract. The DDRB reported its observations in July 2015 and these are currently being considered by the Department.

10. Pending the development of a new mechanism to reward excellent performance, the predominating factor when considering whether to approve any new CEAs in 2012/13 and 2013/14 remains the exceptionally challenging financial situation currently facing the Northern Ireland Executive.

11. Therefore, in light of current financial pressures; pay restraint decisions taken in relation to the HSC more widely; and in order to secure the focus on front line services, it is the Department’s view that it is neither desirable nor affordable to approve any new CEAs for 2012/13 and 2013/14.

Equality Impact Screening

12. The Department carried out an Equality Impact Screening Exercise and asked four questions in the consultation relating to Human Rights and Equality.

Q1: If no new Clinical Excellence Awards are made in 2012-2013 and 2013-2014, is this likely to have an adverse impact on any group of people in terms of the nine equality dimensions?

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Analysis of responses

13. Just over a third of those who responded to the consultation did not answer this question. Of those who replied, two thirds stated that a lack of awards in 2012/13 and 2013/14 would have an adverse impact in terms of the nine groups under section 75 of the Northern Ireland Act 1998. Groups whom it was suggested would experience an adverse impact included age and gender. The respondents asserted that younger consultants would be disadvantaged as they have not had the opportunity to apply and/or progress. The perception of the respondents is that younger consultants are also more likely to be female; they also felt that part-time or female consultants have to work harder and longer than their male colleagues in order to make an impact. The respondents considered that younger consultants are being disadvantaged as they have not been given the opportunity to build up local CEA awards and therefore this results in indirect discrimination against female consultants.

The Department’s Position

14. The Department holds information on the gender of the Consultant workforce which at the time of the consultation stood at 1,522 of which, 985 (64.72%) were Male and 537 (35.2%) were Female. The evidence from previous years indicates that a lower percentage of females apply for awards than their male counterparts. For example, in the 2009/10 awards round, 87.3% of applications for higher awards were received from males, while 12.7% were from females, 79.3% of applications for lower awards were received from males, while 20.7% were from females. In the 2012/13 awards round 84.7% of applications for higher awards were received from males, while 15.3% were from females.

15. The total number of consultants in April 2012 was 1,458 of which 968 (66%) were male; 490 (34%) female. In April 2013 the figures were 1,488 total consultants of which 978 (66%) were male; 510 (34%) female. Eligible candidates for a lower award, those consultants with a minimum of three years experience at consultant level were 505 in April 2012 and 482 in April 2013.
The gender breakdown of this group was 76% male and 24% female in 2012 and 75% male and 25% female in 2013. Eligible candidates for a higher award, those consultants with a minimum of a step 4 award was 253 in April 2012 and 235 in April 2013. The gender breakdown of this group was 83% male and 17% female in both 2012 and 2013. Applications were invited for the award round in 2012/13, the breakdown of these applications is as follows: 98 applications were received from a total eligible pool of 253 (39% of the eligible pool). 83 males (85%) and 15 applications (15%) were received from females. 35% of the eligible females applied and 40% of the eligible males applied.

16. Having reviewed the data currently available there is insufficient evidence to support that view that there would be an adverse impact on females should the awards rounds not go ahead.

Q2: If no new Clinical Excellence awards are made in 2012-2013 and 2013-2014, are you aware of any indication or evidence that this may have an adverse impact on equality of opportunity or good relations?

Responses

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<td>[17%]</td>
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<td>No response</td>
<td>29</td>
<td>[38%]</td>
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Analysis of responses

17. Just over a third of those who responded to the consultation did not answer this question; 45% of the respondents gave the view that, if awards were not made, it would impact on relationships within the medical profession and may also result in consultants becoming unwilling to undertake extra contractual duties. In addition, respondents contended that not awarding CEAs may harm relations within Trusts through reduced morale, reduced efforts on the part of
The Department’s Position

18. The Department appreciates the effect that the Clinical Excellence Awards Scheme has had in contributing towards good employee relations within the HSC. However, the Department is also acutely aware that other health and social care professional groups do not benefit from such a scheme. Given the current financial pressures and pay restraint, the Department would find it difficult to justify the funding of awards for one professional group and not others. In the 2012/13 awards round only 39% of the eligible pool for a higher award actually applied for an award.

Q3: If no new Clinical Excellence awards are made in 2012-2013 and 2013-2014; does this afford the opportunity to promote equality of opportunity and/or good relations?

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<td>[18%]</td>
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<td>No</td>
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<td>[45%]</td>
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<tr>
<td>No response</td>
<td>28</td>
<td>[37%]</td>
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Analysis of responses

19. Just over a third of those who responded to the consultation did not answer this question, and of those who did respond 45% responded negatively. These respondents thought that the resources allocated for use in the clinical excellence awards scheme form part of consultants’ pay bill and should therefore not be allocated to other professional groups. It was also suggested that consultants who are currently working “above and beyond” would become
disillusioned and would as a result stop many key HSC functions; that potential new award holders would be denied access to awards which colleagues, doing similar work, have already attained, and this would be likely to harm good relations between consultants and employers; consultants and the Department; and between groups of consultants.

The Department’s Position

20. The Department recognises the potential for enhanced employee relations with the medical profession, if the decision was made to award Clinical Excellence Awards in 2012/2013 and 2013/14. However it is the Department’s view that the award rounds would amount to a pay increase for those who receive such an award. This is not affordable in the context of the current financial pressures and pay restraint, especially when front line services are seen as a priority. All consultants working in the HSC are placed on an 8 step incremental pay scale which rewards clinicians with an annual incremental increase for the first 5 years of service and thereafter at 5 yearly intervals. The value of the current pay scale ranges from £75,249 at year one to £101,451 after 20 years service. This supports equality of opportunity for all consultants. Consultants who are not on the top point of their pay scale continue to receive either annual or 5 yearly incremental increases. This is in line with the public sector pay policy.

Q4: If no new Clinical Excellence awards are made in 2012-2013 and 2013-2014, are any potential human rights violations likely to occur?

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<td>Yes</td>
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<td>[13%]</td>
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<td>No</td>
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Analysis of responses

21. Nearly half of those who responded to the consultation did not answer this question. Of those who did respond nearly 80% stated that no potential human rights violations were likely to occur.

The Department’s Position

22. The Department carried out an equality impact assessment (EIA) in 2010 and concluded that the decision not to fund any new Clinical Excellence awards in 2010/11 had a neutral impact on consultants’ human rights. The Equality Screening Exercise carried out in 2015 as part of the consultation process supports this conclusion. It is therefore the Department’s view that not awarding any new CEAs in 2012/13 and 2013/14 would have a neutral impact on consultants’ human rights.

Conclusion

23. The Department is grateful to all those who responded to the consultation exercise. A list of respondents is attached at Annex A below.
Appendix A - List of Respondents

The consultation received 76 responses. The respondents were:

Organisations

British Medical Association Northern Ireland
Northern Health and Social Care Trust
Queens University
Royal College of Nursing
Royal College of Physicians UK
Royal College of Radiologists
Sinn Fein
Southern Health and Social Care Trust
The Royal College of Paediatrics and Child Health

Individuals

Dr Nial Herity – Belfast Health and Social Care Trust
Dr Sam Lamont – Belfast Health and Social Care Trust
Dr Enda Kerr – Belfast Health and Social Care Trust
Dr Ian Crawford – Western Health and Social Care Trust
Dr Kevin Glackin – Western Health and Social Care Trust
Dr Maurice O’Kane – Western Health and Social Care Trust
Dr Leo Tumelty – Western Health and Social Care Trust
Dr John Corrigan – Western Health and Social Care Trust
Dr Roz McMullan – Western Health and Social Care Trust
Dr Mary Ledwidge – Western Health and Social Care Trust
Dr Elizabeth Brady – Western Health and Social Care Trust
Dr Nicholas Kelly – Western Health and Social Care Trust
Dr Stephen Todd – Western Health and Social Care Trust
Dr Neil Corrigan – Western Health and Social Care Trust
Dr Danny Acton – Western Health and Social Care Trust
Dr Neil Black – Western Health and Social Care Trust
Dr Philip Gardiner – Western Health and Social Care Trust
Dr Paul McGlinchey – Western Health and Social Care Trust
Dr Ronan McNally – South Eastern Health and Social Care Trust
Dr Nicholas Smith – Western Health and Social Care Trust
Dr Kieran Lappin – Western Health and Social Care Trust
Dr Gerry Mackin – Western Health and Social Care Trust
Dr Albert McNeill – Western Health and Social Care Trust
Dr Ken McCune – Western Health and Social Care Trust
Dr Shiva Sreenivasan – Western Health and Social Care Trust
Dr Rose Sharkey – Western Health and Social Care Trust
Dr Tony Tham – South Eastern Health and Social Care Trust
Dr Diarmaid O’Longain – Western Health and Social Care Trust
Dr Robert Cuthbert – Belfast Health and Social Care Trust
Dr Derek Allen – Belfast Health and Social Care Trust
Dr Charles Ferguson – Western Health and Social Care Trust
Dr Essam Ghareeb – Western Health and Social Care Trust
Dr Sam Hall – Southern Health and Social Care Trust
Dr Philip Charlwood – Western Health and Social Care Trust
Dr Gary McVeigh – Belfast Health and Social Care Trust
Dr Jenny Hughes – Northern Health and Social Care Trust
Dr Patrick Morrison – Belfast Health and Social Care Trust
Dr P. Podmore – Western Health and Social Care Trust
Dr Damien Armstrong – Western Health and Social Care Trust
Dr Girish Shivashankar – Western Health and Social Care Trust
Dr Glen Clarke – Western Health and Social Care Trust
Dr Cian Collins – Western Health and Social Care Trust
Dr Patrick Hassett – Western Health and Social Care Trust
Dr Raymond Nethercott – Western Health and Social Care Trust
Dr Enda Kerr – Belfast Health and Social Care Trust
Dr Graham Morrison – Western Health and Social Care Trust
Dr James Church – Western Health and Social Care Trust
Dr Padhraic Conneally – Western Health and Social Care Trust
Dr Jill Moulden – Western Health and Social Care Trust
Dr Jim Kelly – Western Health and Social Care Trust
Dr Terence McManus – Western Health and Social Care Trust
Dr Gavan McAlinden – South Eastern Health and Social Care Trust
Dr Scott Payne – Western Health and Social Care Trust
Dr Nicholas Lipscomb – Western Health and Social Care Trust
Prof Neil McClure – Belfast Health and Social Care Trust
Dr Chris McConkey – Belfast Health and Social Care Trust
Prof MPS Varma – Western Health and Social Care Trust
Dr Ron Thompson – Western Health and Social Care Trust
Dr Paul Farry – Western Health and Social Care Trust
Dr Gerry Mackin – Western Health and Social Care Trust
Dr Seamus Murphy – Southern Health and Social Care Trust
Dr Peter Passmore – Belfast Health and Social Care Trust
Dr Brendan Devlin – Western Health and Social Care Trust
Dr Brian McCloskey – Belfast Health and Social Care Trust
Dr Angel Ruiz – Western Health and Social Care Trust
Dr Neil McCluney - Western Health and Social Care Trust

Ms Mary M Mahon – Private individual