

Consultation on the reform of the National Clinical Excellence Awards scheme - BMA response

Broadening access to the scheme

ACCEA propose that there should be awards available for roughly 6% of the eligible consultant population, that may be held simultaneously with the local awards or their replacement scheme:

- 1% (about 500) of the eligible consultant population would potentially hold a platinum award, worth at least £40,000 per year*
- 2% (about 1000) of the eligible consultant population would potentially hold a gold award, worth at least £30,000 a year*
- 3% (about 1500) of the eligible consultant population would potentially hold a silver award, worth at least £20,000 a year*

ACCEA propose to drop the bronze level of national awards. The remaining levels, through the single tier application process, will reward national and international achievements.

Under this proposal, each year there would be approximately: 300 new silver awards; 200 new gold awards; and 100 new platinum awards. This roughly doubles the number of awards available each year in England (from 300 to 600).

In Wales, there are currently 2,612 full time consultants. At its current financial level:

- 1% (26) of the eligible consultant population would potentially hold a platinum award, worth at least £40,000 per year*
- 2% (52) of the eligible consultant population would potentially hold a gold award, worth at least £30,000 a year*
- 3% (78) of the eligible consultant population would potentially hold a silver award, worth at least £20,000 a year*
- 4% (104) of the eligible consultant population would potentially hold a bronze award, worth at least £10,000 a year*

Do you agree or disagree that the number of CEAs should be increased so that 1% of the eligible clinical population could hold a platinum award; 2% a gold award and 3% a silver award?

We agree that there should be an increased number of national awards and note the significant reduction in national award holders there are since the unilateral reduction in funding. However we do not agree that the increase in number should be met within the same funding envelope and have concerns regarding the removal of Bronze awards in England.

In Wales, we support the principle behind the 1:2:3:4 ratio, expanding the number of awards available. However, it's important that this isn't seen as an arbitrary cap, or that it doesn't lead to unused resource within the NCEA system. For example, if a particular award has proportionally less applications than others, then it's important that there remains an element of flexibility in the system, with perhaps more awards offered in other categories. All awards should be offered on the basis of quality, and not based entirely on the ratio.

What number of CEAs do you think should be made available, at what level and why, recognising that the costs of the scheme will remain broadly the same?

We agree that there should be an increase in the number of national awards. We were extremely disappointed that the number of national awards in England and Wales were halved from 620 to 310 in 2010. These changes were made in light of the financial crisis in 2008 but despite an economic recovery pre-COVID, these changes were not reversed. The impacts of this decision on the value of the national CEA scheme have been devastating. Indeed, as noted as early as 2011, ACCEA acknowledged in their annual report that “once again we were not able to recommend as many new awards as we found deserving applicants”¹. This trend has continued year on year with many deserving applicants being unsuccessful.

Furthermore, this decision, coupled with the decision not to reinvest funds released by a failure to renew, has resulted in the overall value of the scheme being decimated. Indeed, in 2010, there were 4148 national award holders (excluding L9s), representing 11.23% of the consultant population (ACCEA 2010 report)². This represented a funding envelope of £180,182,315 in 2010 or £219,641,236 in real terms in 2020 (uplifted by CPI of 2% per annum). However, in 2020, there just 2046 NCEA holders in England and Wales, with a total NCEA value of £113,033,062 (ACCEA national report 2020)³. This has not only significantly devalued the scheme but meant that many more deserving applicants go unrewarded. Indeed, the recent COVID-19 pandemic has demonstrated the immense value to the wider population of ensuring that we attract, retain and appropriately reward consultants, public health doctors, consultant clinical academics and academic GPs within the NHS.

In order to correct this, we agree that the number of NCEA awards should be increased. However, we do not agree that the funding levels should remain unilaterally restricted by governments and feel that the overall funding level prior to 2010 was more appropriate to ensure we appropriately reward deserving applicants. Whilst we broadly support the ratio of 1:2:3:4 in Wales including the Bronze award, we feel that overall numbers of awards should be increased with additional funding to bring it in line with pre-2010 levels in order to achieve the stated aim of broadening access to the scheme.

However, we have concerns about dropping the Bronze awards in England and lowering the award value with the expectation that the national and local awards will be held concurrently. Whilst we understand the principle that local awards should be targeted towards rewarding local, employer based work and national awards should reward work with a wider regional, national or international impact, there are a number of problems with this approach.

Firstly, this will result in significant inequity for academic GPs. This group are already disadvantaged as they do not have access to an employer-based awards scheme. Not only does this mean that academic GPs are unable to access employer-based awards earlier in their career, but when they do apply for their first national award, this will be applied for at a higher level (i.e. their first national award would be at Silver rather than Bronze) and yet will be of a lower value. This is detriment is unlikely to be mitigated by the increase in national awards. Furthermore, without access to a local employer-based scheme, academic GPs that are unsuccessful in renewing a national award are unable to access the agreed reversion mechanism allowing them to revert to a local L7 or L8. This proposal will only further increase this inequity, as academic GPs will not be able to benefit from any funding that is transferred from the Bronze awards to the local CEA scheme. In addition, without

¹https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215146/dh_132861.pdf

²https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215962/dh_121388.pdf

³https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/982329/accea-annual-report-2020.pdf

access to an employer-based scheme, academic GPs will not be able to hold employer based and national awards concurrently and will therefore be disadvantaged.

Another area of concern is in relation to the pay protection arrangements for academic GPs that are existing NCEA holders. These pay protection arrangements are contained with the 2003 consultant contract, and there is a lack of clarity as to whether these will automatically transfer to academic GPs, including those on honorary 2003 terms and conditions. If these proposals are implemented, it is essential that a separate employer-based local clinical excellence award scheme is implemented to ensure that academic GPs are not disadvantaged. This is particularly important given the intention to increase the number of academic GPs in the workforce.

Wales, with the system of Commitment Awards unable to concurrently hold Commitment Awards and NCEAs, the NCEA scheme would fail to meet its intended aims if these proposals are implemented, it would be essential that Commitment awards and NCEAs could be held concurrently - including for those with existing NCEAs who had previously relinquished their commitment award.

There are additional concerns relating to how any funding will transfer from the national scheme to the local scheme if award values are reduced and Bronze awards are abolished in England. Under the proposals outlined, existing NCEA holders who successfully renew their award will have their pay protected. However, it is unclear how this will be funded. In England, if this is expected to be funded via the local CEA scheme, this will potentially result in reduced funds available for non-NCEA holders to access when applying for new local CEAs.

In addition, in future, if, as proposed, NCEA holders are able to apply for local awards, there is a high possibility that these high performing applicants will also be successful in receiving high value awards in the local scheme. Unless sufficient central funding is transferred to the local schemes to pay for this, it is highly likely this will result in applicants to the local CEA scheme being disadvantaged and a scenario where, in effect, the local CEA funds have been utilised to increase the number of national awards. Unless there is clarity regarding these funding flows and an assurance that LCEA applicants will not be disadvantaged as a result, the BMA cannot support the proposal that NCEA holders can concurrently hold an NCEA and a local award.

Finally, we are concerned that it will be difficult or indeed impossible to ensure that applicants are not submitting the same evidence for consideration at both local employer-based schemes and to the national scheme for consideration by ACCEA. This raises the very real possibility of overlap, particularly given the scoring processes will be different and may result in 'double payment for the same work'.

Regarding the award levels, as noted above, we have concerns regarding the proposal in England for a consultant to hold a local and national award concurrently and feel that a number of important issues have not been fully considered to date. We also note that the value of awards has been more or less frozen for over a decade. For example, a platinum award based on the 2010 value would be worth around £92,000 if it had kept pace with CPI.

The UK Government has the opportunity, given the events of the last 12 months, to ensure the excellence demonstrated by the medical profession is appropriately rewarded and, as such, increase the funding available to restore the severe pay restraint of NCEAs over the last decade. If NCEAs are to be held concurrently with local awards (assuming the concerns outlined above are addressed), we would recommend award levels of Bronze - £20,000, Silver -£30,000, Gold -£40,000 and Platinum - £50,000 to bring them back in line with their previous inflation adjusted value in England.

Wales specific questions

We are concerned that the proposed NCEA changes and award levels do not fully account for the different structure of pay and reward in Wales, and that this will impact on award uptake and accessibility – with the new proposed levels becoming financially worthless (even detrimental to take home pay) to all consultants after completing 15 years of service. A NCEA system is a valuable, contractual part of the consultant pay bill in Wales. If one of the key purposes for the awards is to drive excellence, then it is crucial that the awards remain both accessible and attractive.

In May 2021, the BMA's Welsh Consultant Committee (WCC) surveyed consultant members in Wales to capture their overall views on NCEAs and the proposed changes⁴. The survey provides some useful insights which help identify a number of ongoing issues with NCEAs:

- Only one in 10 agree (either 'completely' or 'somewhat') that NCEAs incentivise them and it's even lower - one in 16 - for female doctors.
- Almost 75% of respondents to the survey believe NCEAs to be divisive to some extent.
- 70% of respondents believe (42% 'completely') that funding for NCEAs should be repurposed to benefit consultants in different ways.

Do you agree or disagree with the proposed award levels in light that there is no local CEA (LCEA) scheme in Wales?

No.

The current values of NCEAs are intended to act as an incentive to drive quality and innovation, whilst also improving retention of experienced staff. This is because their financial value, at all levels, are attractive to consultants at any point in their career. Consultants on the highest level of Commitment Awards (automatically gained in the absence of an unsatisfactory job plan review as part of overall pay) are still incentivised to apply for a bronze NCEA at the current time, as the value is significantly higher.

However, under the proposed reduced value of the award levels, for any consultant with a level 3 Commitment Award and above, it would be financially damaging to hold a NCEA – the proposals therefore render CEAs worthless for a very large number of the consultant workforce in Wales. If these proposals are to be implemented, it is essential that commitment awards could be held concurrently with NCEAs, including for existing NCEA holders who had previously relinquished their commitment award.

BMA Cymru Wales regards Commitment Awards as a fundamental part of the overall pay package for consultants in Wales. They are automatically applied to all consultants within three years of reaching the top of the pay scale, a point which is reached earlier than consultants in England, and which mitigate some of the lower payscales in Wales at equivalent bandings Commitment Awards command strong support amongst Welsh consultants as part of the overall remuneration package because they are seen as more equitable, more evenly distributed and less subject to conscious and unconscious bias than the previous system of local awards. They play a valuable role in helping to retain consultants in Wales.

⁴BMA Cymru Wales (2021). *BMA Cymru Wales Consultant Survey 2021*. Unpublished. (Survey ran between 18th – 31st May 2021, and received 251 responses)

Wales has had recognised problems with recruitment and retention of consultants amongst certain specialities, as well as within various localities in certain parts of the country. These have often led to services having to be restructured or centralised in ways which have frequently not been welcomed by the public. Commitment Awards are not, therefore, regarded as an 'award' and similarly are not comparable in scope or purpose to national NCEAs or the English Local Clinical Excellence Awards, with these schemes each providing recognition of different outputs entirely. [The DDRB also recognises](#) that, in Wales, the '*current pay scale appears to build in assumptions on progression using Commitment Awards*⁵'. However, despite this, if a NCEA is held, it ceases a consultant's eligibility to receive Commitment Awards.

Because of this, lowering the value of the NCEAs to the levels proposed may therefore have a significant, detrimental impact on their uptake, given that the amount gained from holding a NCEA could be significantly or wholly offset to an individual consultant by the loss of their Commitment Awards. This is particularly the case in relation to the lower level of NCEAs, such as the bronze awards, where it may simply not be seen as worthwhile for a consultant to apply for one. Currently, the bronze NCEA award level is significantly higher than the top of the Commitment Award scale – a NCEA is therefore, currently, always attractive and worthwhile. This is not the case with the proposed new award levels, unless as above they can be held concurrently with commitment awards.

The 2012 DDRB [Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants](#)⁵, highlighted that (in England), the median length of service prior to being awarded a bronze Clinical Excellence Award was 11 years. 43% obtained a bronze award 12 or more years after qualifying as a consultant.

In Wales, due to the nature of the pay scale, many consultants in post for 11 years will be at the top of the basic pay scale, and close to receipt of their second Commitment Award, worth £6,668. Receipt of a non-pensionable bronze award worth £10,000 would only see a relatively small increase in total pay at this point, and will be unlikely to act as a significant incentive, when consultants will receive an equivalent value (£10,002) automatically in Commitment Awards after year 15.

Furthermore, upon reaching this point on the pay scale, there will be no incentive at all for highly experienced doctors to apply for a bronze award – fundamentally because a Commitment Award cannot be held simultaneously with a NCEA, and at this point the Commitment Award is more financially attractive (and received automatically).

Currently, for those in receipt of the highest level of Commitment Awards, the worth of which is £26,672, and the bronze award is worth £36,924. This helps to ensure that wherever you are on the pay scale, there is always an incentive apply for a NCEA. Under the proposals, this incentive will be lost for a significant number of experienced consultants.

Responses to the WCC survey reaffirm this view. Generally, responses suggest that the higher the value of the Commitment Award held, the less likely someone would apply for a NCEA of a similar or lower value. For example, two thirds of those with a Commitment Award of up to £6,668 would consider applying for a bronze Award worth £10,000. However, this drops to two in five for those

⁵Review Body on Doctors' and Dentists' Remuneration (2012). *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226727/DDRB_CEA_Cm_8518.pdf

with a Commitment Award worth £10,002 and to less than one in three for those with a Commitment Award worth over £13,336.

Therefore, we would again offer a qualified answer. We feel that the number and/or value of awards should be increased given the unilateral reduction in funding that happened following the financial crisis in 2008. The funding needs to be restored, but this needs to be done alongside a better recognition and integration of the wider pay structure in Wales.

To this end, we cannot support the proposed values of NCEAs given the pay structure and that in many instances, they would cease to be an incentive to senior consultants in receipt of Commitment Awards. Holding both Commitment Awards and NCEAs concurrently would mitigate much of these concerns. However, if this is not adopted as a solution, then the values should remain as they are until a further agreement can be reached.

In Wales we propose to retain the bronze level award scheme because there is no LCEA scheme in place. Do you agree or disagree that this is a good option?

We acknowledge and agree with the principle that, because there is no local award scheme in Wales, the bronze award should be maintained.

The proposals for England would allow consultants to hold both local awards and national NCEAs simultaneously, which could put Welsh consultants at a disadvantage in terms of their wider remuneration and total reward. The consultation explicitly links the reduction in values of NCEAs to the ability to simultaneously hold local awards – one consultation question asks:

‘Do you agree or disagree with the proposed value at which the CEAs will be set at the different levels, of at least: silver - £20,000, gold - £30,000 and platinum - £40,000, in light of local performance awards also being available to CEA holders from 2022?’

The UK Government has also committed to ‘ensure that this additional cost to trusts is covered’. BMA Cymru Wales therefore call on the Welsh Government to address this disparity, alongside working with trade unions and others to ensure that appropriate incentives and rewards are in place for consultants in Wales. This should also include the option of Welsh consultants not having to give up their Commitment Awards in order to receive a NCEA.

What alternative scheme would you like to see in place?

Our survey asked consultants in Wales what the impact particular proposals would have on their likelihood to apply for NCEAs. The responses we obtained show that the suggestion most likely to encourage more applications for NCEAs would be to enable consultants to hold NCEAs at the same time as Commitment Awards. Almost 40% said they would be more likely to apply for NCEAs if this was the case.

The overarching aim of any NCEA scheme must be to offer an accessible and attractive incentive to achieve excellence and innovation in NHS Wales. However, it is our view that if the values of the awards were to be lowered to the proposed amounts, then NCEAs will no longer be a meaningful incentive for many in the Welsh workforce. We therefore cannot, at this point, support the proposed values of NCEAs if holding such an award continues to restrict a consultant’s eligibility for Commitment Awards.

The simplest and most effective way to mitigate against this is for the Welsh Government to allow Commitment Awards and NCEAs at the proposed values to be held concurrently. This would ensure that applications for NCEAs are always incentivised, and, together with further reforms to the CEA scheme – of which we are supportive - could continue to act as a practical and meaningful retention tool.

If this proposed solution is not adopted, we would recommend the retention of the existing values of NCEAs until a new agreement can be reached between the Welsh Government, employers and trade unions that does not have such potentially damaging unintended consequences.

Local performance awards and NCEAs

ACCEA propose to drop the bronze level of national awards. The remaining levels, through the single tier application process, will reward national and international achievements. The local awards scheme will still recognise local achievement, but subject to the outcome of negotiations could, at the higher end, also recognise regional efforts, such as additional work carried out across integrated care organisations and sustainability and transformation partnerships.

Through allowing consultants to hold local and national awards concurrently, we are increasing the number of consultants who are eligible to receive local awards

In Wales there is no local award scheme, however consultants are eligible to receive Commitment Awards which start to be applied 3 years after a consultant reaches the top of the scale. It is expected that holding a national award in Wales in any new scheme will continue to cease eligibility to hold a Commitment Award, however the current provision enabling consultants to be eligible to return to the Commitment Award scale should they no longer receive a NCEA would remain.

Do you agree or disagree with the proposed value at which the NCEAs will be set at the different levels, of at least: silver - £20,000, gold - £30,000 and platinum - £40,000, in light of local performance awards also being available to NCEA holders from 2022?

Disagree

Changes for domains for assessing NCEA applications

ACCEA propose the following domains for the new scheme:

- Developing and delivering your service*
- Leadership*
- Education, training and people development*
- Innovation and research*
- One other domain in which applicants can provide evidence of any other work of nationally or internationally recognised quality in areas that could include medical care or management, education, health promotion, or research and development*

Do you agree or disagree with these modified domains?

Disagree

What domains would you like to see and why, and/or how would you modify the descriptors provided for the proposed 5 domains?

Increasingly consultants are undertaking a more varied and portfolio-based career. The current system of 'domains' does not adequately capture the breadth of practice across consultants, consultant clinical academics and academic GPs. The suggested changes to the domain structure are broadly helpful, but they do not go far enough to achieve the aim of ensuring that the application process is fairer and more inclusive.

We would prefer a broader choice of domains with the applicant able to choose the domains most relevant to their scope of practice. This will also bring the national scheme more in line with the new proposed local scheme which is likely to have a broader number of areas of excellence, but this is yet to be finalised.

Although we would strongly encourage the inclusion of additional domains, with the applicant choosing up to 5, as noted above the suggested changes are helpful. In particular, we think it is reasonable to combine the old domains 1 and 2 into developing and delivering your service. However, it is important that it is clarified that 'service' may not always be a clinical or patient facing service, and we note that in the past applicants from non-patient facing specialities have been disadvantaged when competing this domain.

This is another reason why additional domains that recognise achievements in non-patient facing specialities would be helpful. Similarly, the previous domain 4, Research and Innovation has historically been a divisive one. There is a perception that this disadvantages consultants that do not have an academic role and work in an exclusively clinical capacity, particularly if they are based in a non-university teaching hospital.

There is some justification for that view, given the proportion of consultant clinical academics (CCAs) that are in receipt of an NCEA compared to their proportion of the consultant workforce. However, conversely, as noted, the previous domains 1 and 2 were sometimes challenging for CCAs if they did not have patient facing roles.

Therefore, we do support the concept that this domain better recognises clinical innovation, but we do not feel that this proposal will represent a significant improvement. Again, we think this provides a compelling argument for additional domains that the applicant can choose from, including separating innovation and research into separate domains. This will ensure a level playing field regardless of the scope of practice of the applicant.

We agree with the proposal to make it clear that domain 3 can also include leading people and teams. We are however conscious that women may be less likely to claim they were 'leading' teams than their male counterparts even if they did in fact demonstrate excellent leadership. We are also aware that, statistically, formal leadership roles remain typically held by men and it would be important to emphasise in this domain that this leadership did not have to be in a formal leadership role in order to be deemed excellent.

In particular collaboration, mentoring, team building and supporting members of a team are all examples of leadership, and applicants do not need to need not be employed in a formal leadership role to demonstrate these qualities. We would also like to see this domain explicitly cover leadership in equality, diversity and inclusion work in the NHS, including supporting the development of colleagues. We think that it is essential that an equalities impact assessment is undertaken with a particular focus on this domain to ensure that it does not discourage or disadvantage female applicants.

For the 5th domain, notwithstanding the fact that we would prefer a greater number of domains, we support the option that the applicant can choose an area of excellence on which to focus on this domain. We note that in a previous version of this guidance, it was suggested that this domain could align with the Care Quality Commission's inspection domains, NHS Long Term Priorities, Secretary of State Priorities, or other NHS priorities such as delivery of the NHS People Plan. We have significant concerns about this and would strongly disagree with excellence being linked to these priorities.

Given that the process is retrospective and political priorities may well change (the current pandemic being a clear example of significantly shifting priorities in 2020-2021), we feel this is inappropriate. There is also the potential of significant overlap, for example a Secretary of State's priorities may relate to a different domain, and it is unclear how this would be taken into account when scoring for this domain. For the proposed new local award scheme, the BMA suggested the following areas of excellence with the applicant being able to choose up to 5:

1. Delivering an excellent patient experience
2. Ensuring patient safety
3. Developing a world-class workforce
4. Delivering cost-effective healthcare
5. Advancing healthcare through research
6. Managing and leading in healthcare
7. Improving healthcare through innovation
8. Education and teaching
9. Working across systems and collaborating with other providers

We would prefer that a similar system is implemented by ACCEA and this will also ensure that there is alignment between the future NCEA and LCEA schemes. We also believe that this system would address the significant inequity that exists for applicants working in different specialities. In particular, we note that, historically, applicants from specialities such as anaesthesia and emergency medicine are significantly underestimated amongst the current NCEA holder cohort and having a greater number of domains available will in our view allow all consultants a better opportunity to demonstrate their excellence.

Improving access to the NCEA competition

Both DHSC and the Welsh Government want to explore options for improving the current application process. Our objectives are to encourage the most deserving applicants to apply for an award and to be fair and equitable, not disadvantaging any eligible group of applicants. As such, it should be devised with diversity in mind.

Alongside this, DHSC and the Welsh Government want to encourage employers to ensure applicants from their organisation reflect the diversity of their consultant workforce, with support for more female and black, Asian and minority ethnic consultants. As part of this, they should consider encouraging applications from traditionally under-represented speciality groups such as palliative care or community paediatrics, with reporting of application diversity against the diversity of their consultant population as a benchmark.

The 'Mend the Gap' review recommended that there should be a closer monitoring of applications and improvement in reporting to help facilitate applications from specialties that are generally in receipt of lower awards.

Those working less than full-time (LTFT) may have their contribution and level of support for an

application assessed against the same standard as a full-time colleague. DHSC and the Welsh Government propose that in future awards should not be paid on a pro-rated basis, but instead be paid at the full award value. This should be a contributory factor in reducing the gender pay gap. We would wish employers to play a key role in encouraging applications from those working LTFT.

Do you agree or disagree with our proposals for improving access to the NCEA competition?

Agree

Do you have suggestions on how we can improve access to the scheme for women and those with protected characteristics?

It is essential that any future NCEA schemes tackle any inequalities that exist at present, and we fully support all attempts to ensure that this is addressed. Whilst, there are some positive recommendations in the proposed consultation, they are not sufficiently comprehensive to tackle the disparities present.

Assessing applications

We welcome the fact that there will no longer be a tiered approach to assessing applications. This was an important factor in the gender and ethnicity CEA gap. This is because within the consultant workforce, a higher proportion of older consultants are white and male, with increased diversity amongst younger consultants. Given the 'ladder' structure of the current award process, holders of the higher NCEAs e.g. gold and platinum will inevitably be older - and as a consequence of the composition of the workforce, more likely to be white and male compared to those holding bronze or local awards.

Pro-rating awards for part-time applicants

We support the proposal that future NCEA awards will not be pro-rata for those working part time. Despite scoring guidance being clear that the score given should reflect the job plan, this does not happen and, as a result, those working part time are judged to the same standard as their full-time colleagues in terms of the volume of work achieved rather than the quality of their work. It is therefore illogical and unfair that they receive a pro-rata award given that this award is rewarding high quality work rather than the amount of work a consultant performs.

Furthermore, if there is a move to these awards being non-pensionable – something we do not support- then it is even more important that these awards are not pro-rated. This is because previously consolidated and pensionable CEAs would increase in the future if the award holder became full time and the pension benefit was based on whole time equivalent pay.

The risk of ending pro rata awards for less than full time consultants is that the standard of excellence they would be expected to attain would effectively be out of reach. There is a balance to be reached in terms of ensuring that the amount paid is fair to those who work part time vs full time whilst ensuring that those working part time are not disadvantaged in terms of qualifying for an award. Again, this is a particular area that needs to be the focus of an equalities impact assessment.

Increasing applications from under-represented groups

We strongly agree that employing organisations should do more to ensure applications are submitted from those in previously under-represented groups.

Changes to the local scheme are underway with a move to participation in the local scheme being expected. Consideration of an auto-enrolment into the NCEA process with the option to 'opt out' rather than an 'opt in' application process may further increase engagement from traditionally underrepresented groups.

However, if this isn't supported by an increase in the number of awards available, this approach may simply set consultants up for disappointment, as many will put time and effort into applying for an award that they are still unlikely to receive despite being excellent, leading to increased demoralization of the workforce. We would therefore only support this if it were linked to a significant increase in the number of awards.

However, we believe that employing organisations need to do more to support applicants with protected characteristics throughout the whole process. We would like to see the introduction of peer-support, mentoring and coaching schemes to help applicants navigate the NCEA system.

There is evidence of an insider/outsider dynamic in the medical system (see GMC Fair to Refer report) which disadvantages some ethnic minority and International Medical Graduate doctors. We are concerned that currently doctors with strong social networks, and better access to senior leaders, are more informed about how to submit a strong CEA application. More support for applicants about how to apply would help to combat this.

We are concerned that the quality of mentoring and support opportunities given may be very inconsistent between trusts. We suggest that national guidance is published to support employing organisations to do this.

Other measures we would like to see are:

- Inductions for new consultants to include more information about the CEA application process.
- Promotional content about CEAs specifically targeted at ethnic minority and women doctors.

More broadly, clear and accessible information about of the award scheme should be promoted, particularly targeted at groups who have previously applied less often. The survey we carried out amongst consultants in Wales found that less than one in five respondents fully understand the NCEA system and how it is administered. There is a notable difference in responses from black, Asian and minority ethnic (BAME) consultants, with over two thirds reporting that they don't understand the system either 'very much' or 'at all', compared to just over one in three of all respondents. The consultation document also states that 'Women and black, Asian and minority ethnic consultants have been consistently under-represented as a proportion of applicants. However, where women do apply, their success rates are now comparable to those of their male counterparts.' Increased awareness and understanding of the scheme and how it works could therefore help to address some inequalities that continue to persist.

Simplification of the application process

Our members have told us that the complexity of the application process can be a barrier to applying. We are particularly concerned about how this affects doctors with caring responsibilities because of the length of time needed to apply. We ask that the application process is simplified, accompanied by clearer guidance about how to apply.

Reporting

We strongly support the proposal that organisations should report on the diversity of applicants for NCEAs. We would like to see employer organisations report on the number of eligible consultants, applications made, and awards granted, and this data should be broken down by protected characteristics. This would allow comparisons to be drawn between employer organisations. Our expectation is that the ACCEA would liaise with employing organisations to ensure that this happens.

Indeed, we have been disappointed that, despite the BMA reaching agreement with NHS Employers and publishing joint guidance that clearly stipulates that trusts in England must produce an annual report on the success rates of applicants in the local CEA system, with detail around distribution of awards for those with protected characteristics, the vast majority of trusts have failed to do this. We note that this has been a significant data gap since ACCEA relinquished oversight of the local award process in 2012 and would ask that ACCEA publish these reports on their website and highlight employing organisations that fail to comply with their requirement to collect this data.

We therefore ask that if this is recommended for the national scheme, that not only is this requirement linked to the existing requirement to produce annual reports for the local scheme, but that this requirement is enforced by DHSC. These reports should also cover what employing organisations have done locally to increase the representativeness of award applicants, progress they have made to addressing any equalities issues, and steps they intend to take in order to address any existing equality issues. These reports should be publicly available.

Evidence shows that some trusts have much higher disparities in applicants and award rates by protected characteristic. We suggest that a threshold is set and trusts that have disparities over this over a period of 3 years are required to submit a detailed explanation of why they think this is and an action plan to remedy it.

Protected characteristic data reporting

We note that ACCEA collect ethnicity data but at present, all ethnic minority doctors are classed under the BAME umbrella. We understand that there may be reasons why this cannot always be further broken down (due to identification for example) but where this is not an issue, we believe that this data should be broken down further as the 'BAME' label may conceal inequalities amongst ethnic minority groups

We would also like to see data reported which shows gender and ethnic minority intersectionally so that we can see the award rates for ethnic minority women.

ACCEA does not currently collect any data on disability. We ask that this is rectified as soon as possible, and that disability application and award rates are collected and reported upon.

The 2019 Annual Report asserts that it isn't possible to suggest disability data as it is not asked on the application form. We strongly recommend that data relating to all protected characteristics is collected on an equality monitoring form which is separate to the application. There is a growing evidence base on inequalities experienced by disabled doctors (eg see [BMA Disability Survey 2020](#)). The BMA is committed to tackling this, but to do this, and to help developed tailored solutions, we need data such as this.

Finally, we ask that collection and reporting of data on application and award rates for overseas-trained doctors is introduced. We are aware that this not a protected characteristic, however, there is a strong evidence base on unequal treatment experienced by overseas-trained doctors.

Time set aside

We note that there is an increasing tendency for employing organisations to reduce time for supporting professional activities (SPA) and that some organisations are 'pro-rating SPA time for those working part time despite their requirements for CPD remaining similar to their full-time counterparts. Job planning and objective setting should encourage work that is capable of being rewarded for excellence.

It is essential that sufficient time is given to all potential applicants to not only develop themselves but to develop services and allow time to complete applications and collect evidence. ACCEA should provide clear guidance on the support necessary and time allocations needed for the application and evidence gathering process for both applicants and employing organisations. This will help to minimize variation and ensure fairness. ACCEA should also request that trusts provide the amount of SPA time available to their consultants to fill their application for the award.

Ensuring the application portal is accessible to all

It is essential that the future online system is compatible with assistive technologies, helping those with visual or other impairments who need to use it. Indeed, we note that the current support for applicants who require assistive technologies is extremely limited and not well advertised. The BMA have suggested to ACCEA that we would be happy to work with them in improving this aspect, and remain willing to do so.

More broadly, clear and accessible information about of the award scheme should be promoted, particularly targeted at groups who have previously applied less often. The survey we carried out amongst consultants in Wales found that less than one in five respondents fully understand the NCEA system and how it is administered.

There is a notable difference in responses from black, Asian and minority ethnic (BAME) consultants, with over two thirds reporting that they don't understand the system either 'very much' or 'at all', compared to just over one in three of all respondents. The consultation document also states that 'Women and black, Asian and minority ethnic consultants have been consistently under-represented as a proportion of applicants. However, where women do apply, their success rates are now comparable to those of their male counterparts.' Increased awareness and understanding of the scheme, and how it works, could therefore help to address some inequalities that continue to persist.

Supporting disabled applicants

We are concerned that current application process do not appropriately support disabled applicants. The only way to alert scoring committees of potential factors, is to enter this information within the 'job plan' section of the application form. Frequently, this is not appropriate, particularly if the nature of the disability/health condition is confidential as these forms are seen by a large number of people, across the employing organisations, potentially national nominating bodies and regional ACCEA scoring committees. This can disadvantage those with health issues if they fail to declare these issues or discourage them from applying all together.

We would like to see the implementation of a confidential process for applicants to disclose ill-health issues or disability to the scoring committee so that applicants are not disadvantaged during the scoring process or discouraged from applying in the first place.

Scoring disabled applicants

Scoring committees should receive training on scoring disabled applicants as part of their equality and diversity training. For instance, if an applicant receives reasonable adjustments in their job plan,

their application should be scored in a way that understands what reasonable adjustments are and takes the applicants adjustments into account.

Scoring committees

We believe there is a need to urgently improve representation from different groups within its committees. Although we are pleased to note that diversity on regional scoring committees is generally improving in terms of gender balance, with the majority of committees having at least a third of who are female, some notable exceptions remain. We are disappointed to note that the chairs and medical vice chairs of the regional committees remain predominantly male.

There is continued under-representation of committee members from ethnic minority groups. For example, the London Northwest committee is particularly poor in this regard with only 4.8% of members being from an ethnic minority background. Once again there is significant underrepresentation of BAME members amongst the chairs and medical vice chairs. However, nowhere is the lack of ethnic diversity seen more than the ACCEA main committee itself. This is unacceptable and needs to be urgently addressed. We ask that the ACCEA develops and publishes an action plan on how it plans to increase representation.

We also believe that scoring committee members must undertake rigorous mandatory training in equality and diversity.

We would also like to see the following measures implemented:

Name-blinding applications

This is important to minimise conscious and unconscious bias.

Feedback to unsuccessful applicants

Our members have told us of the demoralising impact of an unsuccessful application, particularly as the applications are time consuming and complex to complete. There is currently no feedback given to unsuccessful applicants. We ask that a feedback system is implemented.

Clearer guidance on writing applications

Some of our members have raised concerns that applications from doctors who speak English as their second language may be scored less highly, than more persuasively written applications. We would like to see clearer national guidance for applicants on how to write applications.

We are aware that the National Institute of Health Research is currently doing research on the CEA scoring and assessment processes. We hope that this research is published and look forward to reading it. We may suggest further measures to improve the scoring and assessment processes, from an equality and inclusion lens, based on this research.

Introduction of new reporting requirements for employing organisations and sub-committees

Sub-committees which have higher than average rates of disparities in scoring outcomes should be required to submit a statement to the ACCEA Main Committee explaining this.

Ongoing monitoring of the effectiveness of the equality measures implemented

All new measures implemented to try and reduce disparities in application and award rates for under-represented groups should be monitored and evaluated.

Pensions

We strongly disagree with the proposal to make future awards non-pensionable and believe that this will simply entrench the gender pension gap and ‘pull the ladder’ up on the increasing numbers of women entering the consultant workforce who would be considering applying for NCEAs.

The gender pension gap is significantly greater than the gender pay gap and a gap remains even if we fully correct the gender pay gap. As noted above, the majority of current NCEAs and in particular the higher NCEAs are held by older, white men. These are pensionable awards and, given that pension contributions will have been paid on these awards and in many cases annual allowance tax, these awards will be by legal necessity be subject to pensionable pay protection arrangements.

By removing pensionability of awards at the very time we are attempting to broaden access and encourage applications from women is illogical and will simply mean that even if they are successful, these women will never be able to achieve the same level of pension as their older male colleagues who hold existing awards. There are other problems with removing pensionability of awards that are discussed later.

How far do you agree that those working LTFT should be in receipt of the full award value as opposed to the current pro-rated award payment?

Strongly agree.

Our survey of consultants in Wales asked what the impact particular proposals would have on their likelihood to apply for CEAs. One in eight respondents said they would be more likely to apply for CEAs if they were no longer pro-rated for LTFT. Of female doctors who responded, this rose to one in five.

Maintaining excellence during the period covered by a CEA

ACCEA wants to ensure that, in recognising clinical excellence, progress is maintained for the full period that the CEA is in place. At present, only evidence of achievements over the past 5 years is considered in the scoring of applications.

As part of the application process, we are considering asking applicants to provide an outline plan covering the period for which, if successful, the CEA would be paid. This would show how they plan to maintain or continue to develop the work for which they are being recognised. We recognise that applicants’ plans and portfolio of responsibilities may change over time. As such, this is not proposed to be a scored domain, or binding on future applications but to act as a prompt to set out how their contribution will develop over time.

Do you agree or disagree that this is an appropriate way of incentivising the maintaining of excellence during the period covered by a CEA?

Disagree

What proposals do you have to ensure CEA-holders maintain clinical excellence throughout the time they hold the award?

We strongly oppose the proposal to include a plan for ongoing work over the subsequent period in which the CEA would be paid when making an application. By their nature, national CEAs recognise achievements over the preceding five years or since the applicant’s last award and as such are retrospective. Under the current system, future excellence is ensured via the renewals process

which remains highly competitive, with the minimum renewal score closely linked to the minimum score in that region required to achieve a new award at that level.

We understand that, under the current process renewals will no longer apply but that future awards will be limited to 5 years. However, this does not change the fact that the award holder needs to continue to achieve excellence in order to achieve a future award. We do not understand what problem this proposal is trying to rectify and understand from the focus group discussions that this outline plan will neither be scored nor enforced. It is therefore even more difficult to understand how this could be an effective component of the application process.

Furthermore, despite the best of intentions, priorities change often through no fault of the applicant, and intended objectives may become unachievable. We are also concerned about the potential equalities impact of the requirement to submit a such a plan – applicants will have worked incredibly hard over the preceding five years to submit an application but may be planning to start a family or may have fluctuating long-term health issues. For individuals in such a position, this requirement may make them even less likely to apply for a NCEA. Such a discouragement would be particularly problematic given we are seeking to improve the current inequities in the process.

We believe that maintaining excellence should be simple and clear; where a doctor has maintained excellence the renewal (or alternative replacement) process should be fairly straightforward with clear targets that are measurable and the ranking consistent.

As it currently stands, we do not see any advantage in this proposal and, if anything, it is likely to discourage applications, particularly from the very groups we are trying to encourage to apply in the future.

An end to the renewals process

ACCEA propose to retain the 5-year award period, but to end the current renewals process for awards, with clinicians applying for a new award at the point of expiry. This will have benefits and some potential disadvantages. We anticipate that this will substantially increase turnover of award holders at all levels.

Under the present scheme the procedure for applying to renew a NCEA is essentially identical to the process for making an application for a new award. However, maintaining the separation between the 2 types of application is burdensome for both ACCEA's scoring sub-committees and its central secretariat. Needing to process applications for new awards only, will remove this burden and greatly simplify CEA application and administration.

Do you agree or disagree that the 5-year award period should be retained, but ending the renewals process for awards, with clinicians applying for a new award at the point of expiry?

Disagree. In reality this may mean minimal change but there is a need to ensure that there is an overlap period so that, if successful, pay is not lost. There are implications regarding ongoing pensionability in this scenario too.

The pensionable status of NCEAs

The DDRB, in its 2012 review stated that '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 will have the option to make additional voluntary contributions from their award to the NHS (or a private) pension scheme.'

The pensionable status of NCEAs is a legacy from a time when they were treated as permanent salary increases. This does not fit with the idea of a modern, non-consolidated reward scheme.

We recognise that making CEAs non-pensionable may affect consultants at the earlier stages of their careers. We acknowledge that these will include an increasing proportion of women, but expect that this would be offset by increased access of a much greater proportion and number of women and black, Asian and minority ethnic consultants to awards, where they are currently under-represented.

LCEAs have not been pensionable since the current interim scheme began in April 2018 and agreed via negotiations between NHS Employers and trade unions.

Non-consolidated CEAs would be counted as taxable income and as such may still have annual allowance implications for some award holders. However, as a result of the government increasing the annual allowance taper thresholds from 6 April 2020, award holders are able to earn an additional taxable income of up to £90,000 before having their annual allowance limit reduced.

We therefore agree with the DDRB recommendation that CEAs should be non-consolidated and non-pensionable, bringing them into line with LCEAs This will reduce the cost of each award, enabling us to offer more awards.

Do you agree or disagree that NCEAs should be non-pensionable?

Disagree.

We strongly disagree with the proposal to make NCEAs non-pensionable and firmly believe this will simply entrench the gender pensions gap as younger consultants (a higher proportion of whom are female and from ethnic minorities than is the case amongst older consultants) will no longer be able to access pensionable NCEAs. Conversely, older existing NCEA holders will have their pensionable pay protected – something that is necessary given they have paid pension contributions and in many cases annual allowance tax charges arising from their NCEA.

Consequently, removing pensionability of these awards is akin to pulling the ladder up on younger female consultants and simply ensures that they can never achieve a similar pension to their older, male counterparts. We do not accept the argument that this impact will be offset by the increased number of awards and as outlined above, particularly given the events of the last 12 months, there is a compelling argument to reverse the unilateral reduction in NCEA funding that occurred following the financial crash in 2008 and increase the number of awards via additional investment.

There are further problems in respect of making these awards non-pensionable and in particular the interaction with the tapered annual allowance. Whilst it is the case that in the March 2020 budget, the threshold income level was increased to £200,000, this level of earnings is not uncommon amongst those applicants considering applying for higher NCEA awards.

There is the very real possibility that receipt of a non-pensionable NCEA may take an applicant above the level of threshold income with the effect being that it triggers tapering of the annual allowance, which combined with income tax, subsumes the entire value of the award.

This problem is exacerbated by the fact that the applicant may not know what level of award they will receive. This can result in the perverse scenario of an applicant applying in the hope that they

may receive a silver, only to find that they have been nominated for a platinum award, but that due to exceeding the level of threshold income they are actually worse off financially than if they had received a silver.

Although the annual allowance tax charge may be lower if NCEAs were non-pensionable compared to receipt of a pensionable CEA, the key difference is that the tax charge triggered by tapering is for no additional benefit in final pension. Indeed, if utilising scheme pays, applicants could receive a lower pension after receiving a non-pensionable CEA than if they had not received one in the first place.

For example, a consultant at the top of the pay scale, with a 5% on call supplement and a pensionable silver award, has pensionable income of £166k. If they work 3 additional PAs and have £10,000 of additional income, their threshold income is £198k. If they were to receive a platinum award at their first application under the new scheme, this will cause them to exceed the threshold income and trigger tapering of the annual allowance. The consequence of this is that by receiving a platinum award, they would see their take home pay increase by only £5k per year of each of the 5 years after all taxes.

Furthermore, if the additional annual allowance tax bill incurred as a result of receiving a non-pensionable platinum award, which in this example is an additional £10k **for no additional pension benefit** is paid via scheme pays, they could even see an overall reduction in their pension as a result. This means that they could be financially worse off by receiving a platinum award. This is unlikely to be motivate applicants to strive for excellence and will significantly devalue the scheme.

The use of existing provisions for pay protection would also be completely inadequate as they protect *overall* pensionable pay, as opposed to protection of the award itself. For example a 44 year old bronze award holder has current pensionable pay £134,639 (£98,447 basic pay plus a bronze award of £36,192) - this could be protected at that level of *total* pensionable pay. However due to pay growth from both increments and annual pay reviews, assuming 2% pay growth, by age 55 their pay would exceed the protected amount, thereby completely negating the effect of pay protection.

Thus, by age 60 (including increments and 2% pay growth) basic pensionable pay would be expected to be £151,944, thus losing any benefit from pay protection of the award. Had the award been protected separately, even if not subject to inflationary increases, it would produce a pension of £18,173 higher if retiring at 60, and £24,893 higher if retiring at 68. This produces a detriment to the award holder worth between £436k-£498k due to the failure to protect the bronze award separately from overall pensionable pay. We enclose modelling to support these assertions below.

| CP1 | | 2% | | | | | | | 2015 | 1995 | Total pension | 2015 | 1995 | Total pension | Difference | Value to 88 |
|-------------|------|-----|----------------|----------------|---------------|------------|------------------|--|------------------|------------|---------------|--|------------|---------------|------------|-----------------------------|
| | Year | Age | Yrs consultant | Basic Pay 2021 | Basic Pay now | Award | Total with award | Protected Total (total salary) without award | Total with award | | | Protected Total (total salary) without award | | | | |
| 1 | 2021 | 44 | 9 | £98,447.00 | £98,447.00 | £36,192.00 | £134,639.00 | £134,639.00 | | | | | | | | |
| 1.02 | 2022 | 45 | 10 | £98,447.00 | £100,415.94 | £36,192.00 | £136,607.94 | £134,639.00 | £2,567.72 | £39,274.78 | £41,842.51 | £2,530.71 | £38,708.71 | £41,239.43 | £603.08 | |
| 1.0404 | 2023 | 46 | 11 | £98,447.00 | £102,424.26 | £36,192.00 | £138,616.26 | £134,639.00 | £5,211.71 | £39,852.17 | £45,063.99 | £5,999.39 | £38,708.71 | £43,808.10 | £1,255.78 | |
| 1.061208 | 2024 | 47 | 12 | £98,447.00 | £104,472.74 | £36,192.00 | £140,664.74 | £134,639.00 | £7,933.86 | £40,441.11 | £48,374.98 | £7,796.60 | £38,708.71 | £46,415.31 | £1,959.67 | |
| 1.0824216 | 2025 | 48 | 13 | £98,447.00 | £106,562.20 | £36,192.00 | £142,754.20 | £134,639.00 | £10,736.12 | £41,041.83 | £51,777.95 | £10,352.91 | £38,708.71 | £49,016.62 | £2,716.33 | |
| 1.10408003 | 2026 | 49 | 14 | £104,584.00 | £115,469.19 | £36,192.00 | £151,661.19 | £134,639.00 | £13,747.83 | £43,602.59 | £57,350.42 | £13,038.92 | £38,708.71 | £51,747.63 | £5,602.79 | |
| 1.126162419 | 2027 | 50 | 15 | £104,584.00 | £117,778.57 | £36,192.00 | £153,970.57 | £134,639.00 | £16,848.13 | £44,266.54 | £61,114.66 | £15,765.22 | £38,708.71 | £54,473.93 | £6,640.74 | |
| 1.148685668 | 2028 | 51 | 16 | £104,584.00 | £120,134.14 | £36,192.00 | £156,326.14 | £134,639.00 | £20,039.20 | £44,943.77 | £64,902.97 | £18,532.41 | £38,708.71 | £57,241.12 | £7,741.85 | |
| 1.171659381 | 2029 | 52 | 17 | £104,584.00 | £122,536.82 | £36,192.00 | £158,728.82 | £134,639.00 | £23,323.30 | £45,634.54 | £69,957.84 | £21,341.11 | £38,708.71 | £60,049.82 | £8,908.82 | |
| 1.195093569 | 2030 | 53 | 18 | £104,584.00 | £124,987.56 | £36,192.00 | £161,179.56 | £134,639.00 | £26,702.73 | £46,339.12 | £73,041.85 | £24,191.94 | £38,708.71 | £62,908.65 | £10,141.20 | |
| 1.21809442 | 2031 | 54 | 19 | £110,683.00 | £134,921.96 | £36,192.00 | £171,113.96 | £134,921.96 | £30,319.58 | £49,195.26 | £79,514.84 | £27,890.85 | £38,790.06 | £65,800.92 | £13,633.93 | |
| 1.243374308 | 2032 | 55 | 20 | £110,683.00 | £137,620.40 | £36,192.00 | £173,812.40 | £137,620.40 | £34,041.40 | £49,971.06 | £84,012.47 | £30,083.97 | £39,565.86 | £69,649.83 | £14,362.63 | |
| 1.268241795 | 2033 | 56 | 21 | £110,683.00 | £140,372.81 | £36,192.00 | £176,564.81 | £140,372.81 | £37,870.79 | £50,762.38 | £88,633.17 | £33,173.72 | £40,357.18 | £73,530.90 | £15,102.27 | |
| 1.29360663 | 2034 | 57 | 22 | £110,683.00 | £143,180.26 | £36,192.00 | £179,372.26 | £143,180.26 | £41,810.38 | £51,569.53 | £93,379.91 | £36,362.58 | £41,164.33 | £77,526.91 | £15,853.00 | |
| 1.319478763 | 2035 | 58 | 23 | £110,683.00 | £146,043.87 | £36,192.00 | £182,235.87 | £146,043.87 | £45,862.90 | £52,392.81 | £98,255.71 | £39,653.10 | £41,987.61 | £81,640.72 | £16,615.00 | |
| 1.345868338 | 2036 | 59 | 24 | £110,683.00 | £148,964.75 | £36,192.00 | £185,156.75 | £148,964.75 | £50,031.10 | £53,232.56 | £103,263.67 | £43,047.89 | £42,827.35 | £85,875.25 | £17,388.42 | 2015 reduction factor 0.668 |
| 1.372705705 | 2037 | 60 | 25 | £110,683.00 | £151,944.04 | £36,192.00 | £188,136.04 | £151,944.04 | £54,317.83 | £54,089.11 | £108,406.94 | £46,549.53 | £43,683.91 | £90,233.50 | £18,173.44 | £436,642.81 |
| 1.400241419 | 2038 | 61 | 26 | £110,683.00 | £154,982.92 | £36,192.00 | £191,174.92 | £154,982.92 | £58,725.98 | £54,962.79 | £113,688.77 | £50,160.94 | £44,557.59 | £94,718.53 | £18,970.24 | |
| 1.428246248 | 2039 | 62 | 27 | £110,683.00 | £158,082.58 | £36,192.00 | £194,274.58 | £158,082.58 | £63,258.51 | £55,853.94 | £119,112.45 | £53,884.72 | £45,448.74 | £99,333.46 | £19,778.99 | |
| 1.456811173 | 2040 | 63 | 28 | £110,683.00 | £161,244.23 | £36,192.00 | £197,436.23 | £161,244.23 | £67,918.46 | £56,762.92 | £124,681.38 | £57,723.78 | £46,357.72 | £104,081.50 | £20,599.88 | |
| 1.485947396 | 2041 | 64 | 29 | £110,683.00 | £164,469.12 | £36,192.00 | £200,681.12 | £164,469.12 | £72,700.92 | £57,690.07 | £130,398.99 | £61,581.05 | £47,294.87 | £108,965.92 | £21,433.97 | |
| 1.515656344 | 2042 | 65 | 30 | £110,683.00 | £167,758.59 | £36,192.00 | £203,950.59 | £167,758.59 | £77,533.07 | £58,635.77 | £136,208.84 | £66,759.51 | £48,230.57 | £113,990.97 | £22,278.76 | |
| 1.545079671 | 2043 | 66 | 31 | £110,683.00 | £171,113.67 | £36,192.00 | £207,305.67 | £171,113.67 | £82,694.14 | £59,600.38 | £142,294.52 | £69,962.20 | £49,195.18 | £119,167.38 | £23,137.14 | |
| 1.576899264 | 2044 | 67 | 32 | £110,683.00 | £174,535.94 | £36,192.00 | £210,727.94 | £174,535.94 | £87,895.46 | £60,584.28 | £148,479.74 | £74,292.26 | £50,179.08 | £124,471.35 | £24,008.40 | |
| 1.608437249 | 2045 | 68 | 33 | £110,683.00 | £178,026.66 | £36,192.00 | £214,218.66 | £178,026.66 | £93,240.41 | £61,587.86 | £154,828.28 | £78,752.89 | £51,162.66 | £129,935.55 | £24,892.72 | £487,854.44 |

It is also important to note that the major component of some of the very large annual tax charges that were incurred when applicants received a pensionable CEA are driven by large growth in the 1995 final salary scheme. The impact of this is going to progressively reduce over time as everyone in the NHS pension scheme moves to the 2015 CARE scheme. Therefore, when designing a scheme for the future, we do not agree that making NCEAs non-pensionable will improve things in terms of pension taxation. Indeed, this interaction with pension taxation rules, making NCEAs non-pensionable coupled with the uncertainty of the value of award that may be received, risks severely undermining the NCEA scheme and discouraging applications from anyone who may exceed the threshold income if they are successful. This is a similar scenario to the one seen with local CEAs, with some trusts seeing virtually no applications prior to the raising of the threshold income in 2020. Given the higher earnings profile of potential successful NCEA holders, many of these applicants will be similarly discouraged from applying.

Furthermore, we have concerns regarding the provisions both for overall pay protection and pensionable pay protection for existing NCEA holders if these awards are made non-pensionable in the future. It is essential that the pensionable value of the award itself is protected and not just the overall level of pensionable pay as otherwise this will unfairly impact younger NCEA holders compared to their older colleagues who hold awards.

For example, a younger bronze NCEA holder on pay point 5 of the consultant pay scale would expect their basic salary to rise to significantly by the point of retirement as they move to the top point of the pay scale. Therefore, if their pensionable pay is protected simply at an absolute level of pay, they may well be no better off at retirement compared to if they had never received an NCEA and simply progressed up the salary scale. In contrast, an older NCEA could benefit from the protection of the top pay point of the pay scale plus the full value of the NCEA. It is essential therefore that the value of the award is protected beyond the first renewal under any scheme.

We would strongly urge ACCEA to reconsider this proposed change, and strongly believe that awards must remain pensionable; making awards non-pensionable now will disproportionately affect consultants at the earlier stages of their consultant career who are more likely to be women. We do not see how this can be reconciled with the desire to make the process more equitable for women and consultants from ethnic minority backgrounds.

In making NCEA's non-pensionable, the Government would be putting in place a scheme that would place younger consultants (predominantly female and/or from ethnic minorities) at a significant disadvantage compared with their older counterparts. The disadvantage caused by the proposal cannot in our view be a proportionate means of achieving a legitimate aim.

Before implementing reforms to the CEA, we urge ACCEA to give diligent consideration to the impact these proposals would have, particularly with regard to:

- the need to achieve the objectives set out under section 149 of the Equality Act 2010;
- the implications these changes will have for pay, benefits and tax liability for individual doctors; and the depreciation of pension benefits and contributions and the differential impact on individuals because of their age, gender or other protected characteristics.

The consultation document outlines several measures that are characterised as mitigation for the acknowledged adverse impact of the proposed changes to the awards and the transitional interaction of the application, renewal, review and reversion mechanisms. We believe that these measures are either inadequate or that it is insufficiently clear whether and how they will have the

desired and necessary effect. As explained elsewhere in our response, the proposed changes actually appear to undermine the underlying objectives of the CEA in several respects.

Finally, any interference with pay and benefits - including any resulting inequality of treatment - must be demonstrably proportionate and justified in order to be lawful. The proposals in their current form do not provide us with the necessary level of assurance that the legal rights of those affected by the changes would be adequately protected.

The role and value of rankings and citations in the reward process

We propose to improve and streamline the process of ranking and citations for CEAs as described below:

- we propose to retain employer sign off, scoring, levels of support and the provision of employer statements. In addition, we will implement a requirement for employers to provide ACCEA with a statement of their process to ensure equality and diversity and balanced representation of applicants from their eligible population of senior clinicians. We propose to remove any ranking of applicants by employers.

- we propose to review the list of accredited national nominating bodies (NNBs) and specialist societies (SSs) to ensure no specialty or sub-specialty is multiply represented by different bodies, potentially over-leveraging its influence. We wish to ensure that any accredited NNB and SS is of national standing and influence. As above, NNBs and SSs will be asked to provide a statement of their process to ensure equality and diversity and balanced representation of applicants from their membership and the wider specialty

- we propose to limit the number of third-party citations to a maximum of 2. In many cases, we see identical citation text from different sources, there being no quality assurance process possible for such citations

Do you support the changes proposed above for the role of employers?

Do not support

Do you have any other comments on the role that employers should take in a new national award process?

We support the proposal that employers should no longer rank applicants as we believe that this is an important cause of inequity within the awards process and one that discourages many applicants from applying in the first place.

However, we do not agree that the employer should score applicants, outline different levels of support or provide employer statements. The employer's role should be limited to verifying the accuracy of the application and confirming there are no disqualifying criteria in place. This mirrors the arrangements that are in place for the 2021 award round and we believe this is a positive step. The level of employer involvement outlined in the consultation risks further entrenching problems that exist in many organisations whereby only certain applicants are supported.

Furthermore, the employer's statement and score may have a disproportionately high impact on the view of the scoring committee. We do not feel that the requirement for organisations to submit an outline of their processes will provide the necessary mitigation to prevent poor practice.

Do you agree or disagree with the changes proposed for identifying who should be an accredited NNB or SS and reducing potential over-representation of specialties and sub-specialties?

Agree

What criteria should determine whether an NNB or SS should be accredited?

We support the proposal that the list of national nominating bodies (NNB) and specialist societies (SS) should be reviewed to ensure there is no overlap. Where multiple societies/bodies exist that overlap, either the organisations that represents the greatest number of members in that specialty should be the designated body for nominations or they should be encouraged to run the process jointly. Alternatively, where 2 or more societies cover the same field, the applicant should only be able to include one nomination from the same scope of work. We also strongly support the proposal that if multiple citations are submitted, they should not be identical.

However, we do feel that NNBS and SSSs play an important role in assessing the impact of an applicant's work. Many applicants work in relatively niche areas and it is not always possible that scorers can fully appreciate the significance and national impact of this work. The ranking and citation from an NNB/SS can be extremely helpful in providing this context.

We do however agree that the process within each NNB and SS should be standardised as much as possible, that those panels scoring within those organisations are representative of the membership and have appropriate training in equality and diversity, and that a statement outlining their process should be provided. We feel that NNBS/SSs should continue to produce ranked lists and we also believe that they should assess the overall contribution of the applicant to their specialty and the wider NHS and not prioritise work done by the applicant directly for their own organisation. Indeed, this could lead to further bias and inequity as those from minority groups are less likely to have prominent roles within NNBS/SSs.

We agree with the proposal to limit third-party citations to a maximum of 2.

How far do you support the changes proposed for third-party citations?

Support

Any further comments on future arrangements for the NCEA scheme

Do you have any additional proposals or further comments on future arrangements for the NCEA scheme

We would like to take the opportunity to reinforce the importance of ensuring changes to the NCEA system fully take into account the needs the Welsh health service and reflect the differing pay and reward context in each nation. If the proposals were to be implemented in Wales as they currently described, it would have a significantly detrimental impact on both the aims of encouraging excellence and innovation in Wales, as well as retaining senior consultants within NHS Wales.

The value of NCEAs will cease to act as an incentive in Wales from a much earlier stage of a consultant's career, given the condensed pay scale and the automatic application of Commitment Awards. It's crucial that changes are made to either allow NCEAs and Commitment Awards to be

held concurrently, or to maintain values of NCEAs that are higher than the top level of Commitment Awards, to avoid unintended and potentially disruptive and damaging consequences for the Welsh health service.
