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MSC Response to the Review of the Clinical Excellence Award Scheme

The Medical Schools Council

The Medical Schools Council represents the interests and ambitions of the UK's 32 Medical Schools as they relate to the generation of national health, wealth and knowledge through biomedical research and the profession of medicine.

As an organisation it occupies a unique position embracing medical undergraduate education, the entirety of health related research and a critical interface with the health service.

This response has been seen and agreed by all 32 member Medical Schools.

Response

The Medical Schools Council believes that the removal of national clinical excellence awards would, at a stroke, destroy the future clinical leadership of the UK and inflict potentially terminal damage upon both the provision of cutting edge patient care and upon the UK's health economy.

In its submission the MSC wishes to focus on the particular issues surrounding clinical academics.

There is clear evidence that basic and clinical research lead to improved patient care and that such research also links directly to wealth gain through the pharmaceutical and related industries. Clinical academics play a crucial role at the fulcrum of the triangular relationship between the NHS, the University sector and the Pharmaceutical/Medical Devices industry. If clinical excellence awards were withdrawn a brain drain would result, with a disastrous impact on R & D, on innovation in the NHS and on the UK's economy.

The national CEA scheme is critical to the recruitment and retention of senior clinical academic and other senior clinical staff in the UK's clinical academic centres. It is of central importance to the integrated approach to clinical service provision, education and research, which underpins the success of the UK's centres of clinical excellence. The White Paper, *Liberating the NHS*, emphasises the importance of research to the NHS. The clinical excellence scheme forms a fundamental part of the research architecture rewarding as it does, the long term commitment of clinical academics.

It has been clearly demonstrated that there are, unfortunately, powerful disincentives to embarking upon a clinical academic career: CEAs have been a useful counter-balance which provides the necessary incentive for younger clinical academics to sustain their academic pursuits in research and teaching despite the concomitant financial disadvantages – it takes longer for an academic to train in order to

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achieve the required additional higher qualifications. The CEA scheme has provided a longer term financial reward for world class clinical scientists who have progressed their careers in academic medicine to the benefit of the NHS. The commitment and dedication of many clinical academics is daunting – CEAs provide them with some compensation for eschewing the greater pecuniary rewards that would have been available to them had they entered other branches of the profession.

In addition there are around 200 senior academic GPs in the UK. Those that hold clinical excellence awards provide substantial benefits to the NHS through:

- Research to provide the evidence-base for high quality health care;
- NHS service development;
- Management and leadership;
- Clinical education;
- The provision of high quality clinical care.

Without access to clinical excellence awards, the vast majority of full-time senior academic GPs would earn substantially less that the average full-time GP partner. Therefore, if awards were substantially scaled-back or withdrawn, this would seriously affect retention of the most talented and experienced senior academic GPs, with subsequent loss to the health service. Recruitment to academic general practice would also be seriously damaged because of the lack of future financial reward compared with a career as a GP in clinical practice.

In the absence of clinical excellence awards it would be impossible to attract senior individuals with cutting edge clinical skills, which mesh with NHS R&D research priorities, to the UK from G20 countries. The top of the consultant scale is not sufficiently attractive to induce these talented clinicians to work in the UK – the incentive of a clinical excellence award, essentially serving as a realistic market supplement, is an absolute necessity.

The scheme is equally important to retain the UK's top flight clinicians in the NHS and this will become increasingly important with healthcare delivery moving to a more diverse range of providers. The basic NHS salary is not competitive in the private market. The new Dean at UCLA Medical School, for example, is paid $700,000 a year plus benefits (only 3.12% above the median for the market, *see* Annex 3). A senior UK clinical academic with 15 years' experience as a consultant and a platinum clinical excellence award would earn £159,625 or $254,127.

Indeed the Scottish Government's decision of 16.11.10, to freeze the value of distinction awards and discretionary points and allow no new awards in 2011/12, and its statement in advance of the findings of this Review that *the current awards scheme needs substantial reform in order to make it sustainable, fit for the future and value for money* is likely to have a damaging effect on the retention and recruitment of clinical academics in Scotland and on future research and innovation.

The vital importance of clinical academics to improved patient care in the NHS cannot be over-estimated. Academics have had a central and major role in the development of novel services and treatments in the NHS where:

- their vision and energy has developed innovative services now embedded within the NHS, for example cardiothoracic transplantation and laparoscopic surgery

- they have led the establishment of multidisciplinary clinical teams
- they have led the establishment of patient-focused care

Clinical academics have advanced healthcare by delivering research for patient benefit that has been judged as nationally and internationally excellent. Research and innovation are vital to the future development and success of NHS services. CQC data demonstrate year on year that the highest standards of clinical care are delivered in research informed environments and teaching trusts. Moreover it is clinical academics who secure the majority of the funding for research that benefits patients (allied to portfolio-related NHS income – examples include NIHR Research for Patient Benefit, Diabetes UK, Biomedical Research Centres and Units etc).

There is already a national shortage of clinical academics. Removal of the CEA scheme would bring about the very real risk that the corpus of clinical academics would drop to dangerously low levels, indeed 62% of clinical academic doctors are already aged over 46.[1] Not only will this damage patient care, but it would also remove the ability to conduct the Pharma-driven clinical trials for which clinical academics are largely responsible and which represent a huge commercial benefit to UK plc.

Clinical academics also take on a disproportionate number of voluntary leadership roles in medical charities, patient support groups, Research Council UK committees etc. These are all vitally important committees that sustain internationally recognised quality in the profession.

The most senior clinical academics have made a sustained effort – with a commitment of over 25 years, sacrificing higher incomes over that period of time compared to their peers who worked in both NHS and private sectors. The national CEA scheme is a fair, transparent and increasingly rigorous way of recognising the additional work performed by these exceptional clinicians who devote their creative efforts to bringing about evidence based, effective change for patients and the NHS.

We have examples from the vast majority of Medical Schools where salaries at the level of at least a Silver award have had to be made to secure the recruitment of top flight UK and overseas clinical academics. In almost all cases, the contribution of these individuals to the NHS is swiftly made, and the national scheme delivers the award.

In Scotland for example a salary at the NHS Scotland B distinction award level was necessary to recruit a world expert in cardiopulmonary radiology as part of the NHS R&D (CSO) -sponsored SINAPSE imaging R&D Network. Thus this was an international recruitment driven by NHS R&D aspirations to bring together world class expertise in imaging science and radiology. The R&D mission benefited, as has clinical delivery.

In another part of the country an academic with PET expertise was sought to fill the Chair of Neurology – an unusual combination – but vital in the search for cures for brain cancers. Again, only a salary at the level of the national clinical excellence awards was sufficient to effect the appointment.

Examples have been identified of senior highly skilled clinicians who have returned from overseas or industry because they felt that the CEA for NHS clinical academic work would offset the financial dis-benefits of returning to academic posts within the UK.

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[1] Medical Schools Council (2010) *Survey of Clinical Academic Staffing Levels in UK Medical and Dental Schools*

However even such payments may be insufficient. For example one medical school gives an example where it recruited an outstanding clinical academic from Germany utilising the equivalent of a CEA award on the basis that it recognised he would achieve this in a short time once he had begun work in the UK. Unfortunately, the School was trumped (after he had signed his contract) by a North American university which offered a substantially enhanced salary that it could not match.

There is no doubt that the national CEA system is critically important to develop, incentivise and most importantly retain the best staff for the NHS.

MSC accepts that a regular review of awards should take place and that the system must permit the financial benefit to be withdrawn if the individual no longer merits the award.

While MSC would support the review and possible abolition of local awards, to focus on excellence of true national significance, it is absolutely vital that the national scheme be maintained. ACCEA has worked hard to ensure that the current scheme is both fair and entirely transparent. Going forward, a national scheme could provide a bench-marked, quality assured and independent process which ensures that only the most deserving receive awards in a way that is externally moderated and refereed. Whilst the DDRB Review currently focuses on the England and Wales awarding body, ACCEA, the MSC strongly believes that the principles of a scheme to recognise the exceptional contributions of clinicians should apply in each of the four UK countries.

The MSC would be happy to provide further, oral evidence to the DDRB.

Annex 1

A few specific examples of developments pioneered by clinical academics that have impacted on novel treatments include:

- the key role in the development of innovative services now embedded within the NHS, for example cardiothoracic transplantation
- the identification and development of serum markers of fibrosis now available as routine
- enhancing the safety of blood transfusion
- the establishment of novel therapies for previously intractable lung disease such as pulmonary fibrosis now being trialed in experimental medicine studies
- the development of major novel interventions/approaches that have revolutionised clinical care such as laparoscopic surgery
- IVF and related practices that have been widely adopted in the clinic and led to spin-offs including pre-implantation genetic diagnosis and stem cell technologies
- Health Select Committee's Inquiry on AIDS, 1987, recognised that clinical academics were pivotal in the early clinical (NHS care and treatment delivery) and public policy (DH and other departments of state) response to HIV and AIDS.
- tertiary referral centres for neuromuscular disease and mitochondrial diseases have been set up by clinical academics that have developed impressive national and international reputations and are seen as a jewel in the crown of the NHS
- Research to provide the evidence-base for high quality NHS health care

  eg, the RCGP oral contraceptive study which has provided important evidence on the safety of oral contraceptives

- the use of Natriuretic peptides in the diagnosis and management of heart failure
- self-management of oral anticoagulation, screening and treatment of atrial fibrillation
- the MRC funded case-control study of MMR vaccination and autism, widely credited with restoring public faith in the vaccine
- the development of screening tools:
    - QRISK2 for cardiovascular risk, the FRAT for falls risk in older people, and HARK for domestic violence

The 2010 White Paper, *Equity and Excellence, Liberating the NHS*, acknowledges that NIHR has been a success but the reality is that much of this has been driven by clinical academics. For instance all of the subject-specific Clinical Research Networks are housed in University departments and led by clinical academics. In addition, the success of the NIHR Biomedical Research Centres and Units has been driven by clinical academics working with partners in the NHS.

Annex 2 - Examples of Roles played by Clinical Academics

Clinical academics have held, and hold, the majority of senior positions within NHS groups/committees allied to training and research. If the awards did not exist, additional payments would have to be made to compensate for the time devoted to such activities

The following are just a few of the international, national and local roles played by Clinical Academics with national Clinical Excellence Awards. The crucial input of some clinical academics at a national level is not always readily visible; an example would be their leadership roles in the HPA and Ministry of Defence.

The Chair of the GMC, the Chief Executive of the Wellcome Trust and the last two Chief Executives of the MRC have all been clinical academics – two of them still see patients every week. The last three Chief Scientists in Scotland have all been clinical academics. Two recent Chief Medical Officers, Scotland have been Clinical Academics.

Chairs of Non-Governmental Public Bodies for the DH, for example:

- Chair, Joint Committee on Vaccination and Immunisation (JCVI)
- Chair, National Clinical Audit Advisory Group (NCAAG)
- Chair, Infectious Diseases and Microbiology Research Group, NIHR Clinical Research Network Coordinating Centre
- Co-Chairman (with Govt Chief Scientist) of the UK's first Scientific Advisory Group for Emergencies (SAGE)
- Deputy Chairman and member of the United Kingdom Advisory Panel for Healthcare Workers Infected with Bloodborne Viruses (UKAP), Health Protection Agency
- Chairman of the Scottish Government National Dental Advisory Committee (NDAC)
- Chair of the Coronary Heart Disease and Stroke: Strategy for Scotland
- Chair of Public Health Institute of Scotland (est. 2000)
- Multiple Chairs and members of NICE committees, for example the Coronary Heart Disease and Cardiovascular Prevention National Standards Development Groups
- Multiple Chairs and members of SIGN guideline development groups

Chairs of Independent Inquiries for Secretaries of State, for example:

- Inquiry into Modernising Medical Careers: Aspiring to Excellence (2008)
- Review of NHS dental services in England for the DH (2009)
- Review of the UK Organ Donor Register (2010)

National Clinical Directors and Leads, for example:

- Clinical Director of NHS Choices
- Clinical Director of Urgent and Emergency Care, DH
- Clinical Director of national ambulance clinical guidelines project
- Clinical Lead NHS Evidence (emergency and urgent care)
- Clinical Lead for Quality Improvement Scotland
- Lead Assessor, Scottish Medicines Consortium: New Drugs Committee
- Lead for Colorectal Cancer Screening for Scotland (having pioneered evaluation of this across the UK)

- National Clinical Lead for electronic health and informatics

Additionally clinical academics hold or have held senior roles in local and national NHS-related training, for example:

- Chairman of local STCs
- Chairmanship and membership of SACs
- Educational supervisors
- Presidents of specialist societies
- Leadership roles within specialist societies
- Council membership of medical Royal Colleges and specialist societies

Annex 3 - Compensation package for the Dean at UCLA

Appointment of and Compensation for A. Eugene Washington, M.D. as Vice Chancellor – Health Sciences and Dean of the David Geffen School of Medicine, Los Angeles Campus

Approval is requested for the appointment of and compensation for A. Eugene Washington, M.D., M.Sc., as Vice Chancellor – Health Sciences and Dean – David Geffen School of Medicine, Los Angeles campus, effective February 1, 2010. The UCLA campus has concluded a national search and Dr. Washington has been selected as the top candidate for this position. Dr. Washington emerged as the leading candidate because of his extensive experience in the academic medical enterprise setting, and his national leadership in areas such as assessing medical technologies, developing clinical practice guidelines and establishing disease prevention policies, particularly for women's health. He is an internationally renowned clinical investigator and health policy analyst who has been actively engaged in the training of medical students, residents, fellows, and junior faculty at the University of California, San Francisco. Dr. Washington was elected to the Institute of Medicine of the prestigious National Academy of Sciences in 1997. He has received numerous other national and international honors and forms of recognition.

The proposed annual base salary is $515,000 and is 3.12 percent above the market median of $499,400. Market data were provided by Mercer Human Resource Consulting using the 2008/2009 College and University Professional Association (CUPA) Administrative Compensation Survey for UC's Full Comparison Group. The proposed base salary is funded 100 percent by UC general funds provided by the State. Health Sciences Compensation Plan funds are derived from medical C Report -11- January 21, 2010 enterprise revenue. This position is subject to the University's salary reduction/furlough plan. The Committee recommends approval of the following items in connection with the appointment of and compensation for Dr. A. Eugene Washington as Vice Chancellor – Health Sciences and Dean – David Geffen School of Medicine, Los Angeles campus:

1) Appointment of A. Eugene Washington as Vice Chancellor – Health Sciences and Dean – David Geffen School of Medicine at 100 percent time, effective February 1, 2010.
2) An appointment salary of $515,000 and Health Sciences compensation (under the Health Sciences Compensation Plan) of $185,000, for total annual cash compensation of $700,000.

<u>Recommended Compensation</u>
Effective Date: February 1, 2010
Base Salary: $515,000
Health Sciences Compensation: $185,000
Grade Level: Grade 114: Min $372,900 Midpt $483,400 Max $593,800
Median Market Data: $499,400 (base only)
Funding Source: UC General Funds for base salary and medical enterprise revenue for HSCP
Percentage Difference from Market: 3.12%
Budget &/or Prior Incumbent Data
Base Salary: $530,000
Health Sciences Compensation: $207,000
Grade Level: Grade 114
Funding Source: Combination of UC General Funds and medical enterprise revenue
<u>Additional items of compensation include:</u>

- Per policy, standard pension and health and welfare benefits and standard senior management benefits (including senior management life insurance, executive business travel insurance, and executive salary continuation for disability)
- Per policy, accrual of sabbatical credits as a member of tenured faculty
- Per policy, ineligible to participate in the Senior Management Supplemental Benefit Program due to tenured faculty appointment
- Per policy, reimbursement of costs associated with two trips to secure housing in the Los Angeles area up to a total of $2,500 for coach airfare, meals and lodging for the candidate and his spouse. C Report -12- January 21, 2010
- Per policy, a 25 percent relocation allowance of $128,750, to be paid in annual installments over three years: 50 percent ($64,375) in year one, 30 percent ($38,625) in year two, and 20 percent ($25,750) in year three. The relocation allowance is subject to repayment on a pro-rated basis, should the appointee leave the University prior to the completion of three consecutive years of service
- Per policy, reimbursement of temporary housing expenses for up to three months at $4,000 per month, not to exceed $12,000 total
- Per policy, reimbursement of 100 percent of reasonable and allowable expenses associated with moving
- Per policy, eligibility to participate in the Mortgage Origination Program for a loan of up to $1.33 million.

The compensation described above shall constitute the University's total commitment until modified by the Regents and shall supersede all previous oral and written commitments. Compensation recommendations and final actions will be released to the public as required in accordance with the standard procedures of the Board of Regents.

Annex 4 - List of acronyms

CQC	Care Quality Commission
CSO	Chief Scientific Officer
GMC	General Medical Council
HPA	Health Protection Agency
JCVI	Joint Committee on Vaccination and Immunisation
MRC	Medical Research Council
NCAAG	National Clinical Audit Advisory Group
NDAC	National Dental Advisory Committee
NIHR	National Institute for Health Research
PET	Positron emission tomography
QRISK2	cardiovascular disease risk calculator
RCGP	Royal College of General Practitioners
SAC	Specialist Advisory Committee
SAGE	Scientific Advisory Group for Emergencies
SIGN	Scottish Intercollegiate Guidelines Network
SINAPSE	Scottish Imaging Network - A Platform for Scientific Excellence
STC	Specialist Training Committee
UKAP	United Kingdom Advisory Panel
UCLA	University of California, Los Angeles