



From: The President

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Renal Association: Response to Consultation on Distinction Awards

The Renal Association is the professional body for nephrologists and renal scientists in the UK. The great majority of consultant nephrologists in the UK are members. A significant minority of nephrologists participate in the unselected medical 'take'. Opportunities for private practice in nephrology are limited. This response is a synthesis of responses to a consultation within the Consultant membership of the Renal Association.

The ACCEA scheme is intended to reward work 'over and above that expected'. It is clear from review of the application forms of applicants to the ACCEA scheme that very many doctors are working well beyond their contract, in diverse ways that do not bring income directly to their employing institution, but which are nevertheless – arguably – of enormous value to the NHS. These activities include, but are not limited to

- Research (particularly relevant when not part of the 'day job', i.e. when undertaken by non-academic staff)
- Teaching (over and above contractual expectations, for instance the development of new teaching methods, the revision of curricula and the design and implementation of new assessment methods for medical students and doctors in training grades)
- Quality Improvement, innovation, and service development
- Specialty-specific work, in particular the development of clinical practice guidelines
- Work for Royal Colleges
- Work for DH and other Advisory Bodies

It is clear that many Consultants (and a significant number of senior practitioners who are not medically qualified, and thus do not qualify at all for ACCEA) spend considerable time on these and other activities. While few, if any, consultants undertake such activities solely in the hope of receiving recognition in the form of local or national awards, it is also clear that the possibility of such an award does provide a powerful motive to continue such work, most of which is undertaken 'out of hours', even though only the minority of highly productive consultants receive national awards for this type of work. Removing this incentive could create a situation in which the majority of Consultants would stop, or greatly reduce, their contributions outside a narrow interpretation of their contractual commitment. Some individuals would move into private practice, the pharmaceutical industry, or to posts outside medicine that were better rewarded. The net consequence would be a marked reduction in these activities, with potential disastrous consequences for the NHS.

Disbanding the ACCEA scheme would also create inequity and tension between senior award-holding consultants and more junior consultants who would stand no chance of ever getting the same level of remuneration.

Academic nephrology is seen as a more precarious career choice than clinical nephrology. There are unfilled teaching and research posts in academic medicine. The great majority of

academic nephrologists do little or no private practice, and may have significantly lower income as a result than their colleagues in NHS practice who also practice privately. In addition, consultants in clinical practice have the opportunity to augment their income in the form of additional programmed activities, and this opportunity is seldom available to clinical academics. In the past, the ACCEA scheme was one way in which this imbalance could be redressed. However, the recent revision of the scheme, in which achievement in all 5 domains is seen as equally important, has reduced the likelihood that clinical academics, particularly in disciplines in which there is no direct service provision or opportunity to develop the service, will be receive recognition in the form of an ACCEA award. (However, there have been some improvements: in previous years, many clinical academics with external grant funding were not even eligible for awards). This creates the real danger that medicine, and particularly those branches of medicine in which there are limited opportunities for private practice, will become increasingly less attractive to the brightest school leavers, thus 'dumbing down' the profession and reducing the chances that the UK will continue to punch above its weight in research. Academic medicine in the USA has, arguably, suffered as a result of the gap in remuneration between academic medicine and private practice.

Suggestions for how the scheme might be improved

The majority view was that the scheme operates is clear and transparent, and much less susceptible to the personal influence and opinion of small numbers of highly influential people than previously. However, several correspondents suggested improvements:

- The present scheme relies heavily on self-reported activity, and such reports do not always give an accurate picture of true activity. However, whether the additional bureaucracy involved in gathering more input from patients, colleagues, managers, and senior clinicians, would result in fairer outcomes remains in doubt.
- A simplification of the scheme to three tiers, at 25%, 50%, and 75% of the prevailing 10-year consultant salary, at a minimum of 7 years, 14 years, and 21 years of service as a consultant, was proposed.
- Several academic nephrologists argued that the requirement to score highly in all 5 domains was inequitable, effectively discriminating against those whose work was primarily academic (for instance, laboratory-based or epidemiological) and who have no real opportunity for service development or clinical management.
- The scheme fails badly on provision of feedback to unsuccessful candidates; it is insufficient to state that there were not enough awards for deserving candidates.
- Some correspondents suggested reduction of the local award scheme with reallocation of the money spent towards a regional award scheme or an extension of the national scheme.
- One clinician argued that greater emphasis should be placed on direct clinical care – the quality of clinical consultations and the contribution of clinicians to patient support groups, etc.

Summary

The Renal Association strongly supports the retention of an ACCEA system that will provide incentives for NHS consultants to continue to contribute 'above and beyond' their contracted duties. Further reduction in the number of awards, or complete abolition of the system, will risk encouraging a 'blue collar' mentality, resulting in far fewer such contributions. The Renal Association strongly believes that these activities add enormous value to healthcare in the UK, in all domains. Paying for these activities at full cost would be enormously more expensive than the present incentive system, in which the prospect of an award motivates far more people than will ever be likely to receive one. The scheme should be further revised, to allow recognition of all senior clinicians of all descriptions; and this revision should include modification of the current requirement to demonstrate excellence in all 5 domains.

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