



Department  
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Social Care

# Equality Analysis on the proposed amendments to Clinical Excellence Awards (CEAs) for Consultant graded doctors in the NHS in England

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# 1. Introduction

1.1. CEAs in their current format were introduced in 2004 and offer performance payments to consultants of between £3,016- £77,320 that are often payable for an individual's entire career. Awards are made on a local level (which are paid for by employers and range from £3,016- £36,192) and nationally (which range from £36,192- £77,320).

1.2. In 2012 the Review Body on Doctors and Dentists' Remuneration (DDRB) published a report on the CEA scheme. Their recommendations included that in future local CEAs ("LCEAs") should be time limited, payable for up to 3 years and non-pensionable. Further recommendations on performance pay from the Public Accounts Committee have also been accepted by the government. The principles of these recommendations have informed the basis of a new draft Schedule to the 2003 national contract for Consultant graded doctors.

1.3. This paper

(a) analyses the draft new Schedule to the 2003 national contract for Consultant graded doctors in the National Health Service ("the NHS") ("the amended contract") in order to assist the Secretary of State for Health and Social Care ("the SoS") in giving effect to his Public Sector Equality Duty ("the PSED") under s149 of the Equality Act 2010 ("EqA"). This requires the SoS to have due regard to each of the statutory equality objectives (or strands) set out in s149 EqA (s149 is set out in full in Annex A).

(b) provides an analysis of the expected equalities impact of the changes informed in part, but not exclusively, by:

- the likely/foreseeable impact of the revised terms of the scheme;
- the available data on the makeup of the current cohorts of Consultants, and doctors in training in the Specialty Registrar and Core Medical grades, who are training to be qualified for entry on the General Medical Council's Specialty Register, a pre-requisite for appointment to a consultant graded doctor post in the NHS in the UK, by reference to protected characteristics (see Table V);
- engagement and negotiation between the British Medical Association ("the BMA"), the Hospital Consultants and Specialists Association ("the HCSA") and NHS Employers ("NHSE") regarding the development of the amendments to the contract.

(c) assists the SoS in considering whether the proposals developed by the negotiating parties should be approved and/or should be subject to amendment before a firm offer of the amendments to the contract is made to the BMA and HCSA by NHS Employers.

1.4. Further work on the equalities impact of the amendments to the national contract will continue after it is introduced to ensure on-going compliance with the SoS's PSED. Local employers will be encouraged in implementation guidance to publish detail regarding those who have been awarded LCEAs. The published data should not be such as to be able to identify specific individuals; however a breakdown of equalities information relating to award recipients should be made available. Equalities data can be used to monitor the impact of the changes to the LCEA scheme and to inform any

proposed future amendments, thus contributing to the on-going PSED. Examples of good local practice can also be shared to assist employers to use their flexibility to improve the overall equality of the scheme where required. Equalities data regarding those awarded NCEAs is already published annually by ACCEA.

- 1.5. Employing organisations also have a PSED and will need to conduct their own equalities impact assessment of the introduction of the amendments to the contract and on-going operation of the local schemes.
- 1.6. In EU and UK discrimination legislation, there is a fundamental distinction between direct discrimination, on the one hand, and indirect discrimination on the other.
- 1.7. Direct discrimination is where an individual receives less favourable treatment directly because of a protected characteristic.
- 1.8. Indirect discrimination concerns a provision, and criterion or practice (“PCP”) that puts someone with a protected characteristic at a particular disadvantage, compared with people who do not share the protected characteristic. However, a PCP that causes a particular disadvantage is lawful if it is a proportionate means of achieving a legitimate aim. In relation to disability, it may also be appropriate in certain circumstances to take positive action to remedy a disadvantage that would otherwise arise.
- 1.9. In preparing this equality analysis, consideration has been given to all of the statutory objectives under s149 EqA.

## 2. Key objectives of introducing a new Schedule to the consultant contract

- 2.1. There is a strong case to modernise the local CEA scheme in ways that will reward consultants more fairly. The proposed new Schedule contains interim arrangements covering up to three years 2018-21 and a set of post 2021 arrangements. It is intended that both parts will be superseded by a full contractual agreement before 2021 but if that is not the case, the post 2021 arrangements provide a default position going forward that preserves the key elements for both sides.
- 2.2. The following broad objectives and principles have informed a negotiating process between the BMA, the HCSA and NHS Employers. The proposals should:
- ensure performance awards are distributed fairly
  - ensure there is a stronger link between excellent performance and reward based on a fair way of assessing current excellence
  - make future awards non-pensionable and time limited for a maximum of three years
  - clarify employers' flexibility to introduce further changes locally, such as creating a clearer link with organisational objectives
  - introduce a review process for existing awards from April 2021 with further changes subject to later collective agreement
  - result in a scenario where future talks would aim to agree more comprehensive changes as part of a wider deal on contract reform
  - gain commitment from employers to guarantee per FTE funding on local performance pay based at current spending levels beyond the transitional period

## 3. Who will be affected?

- 3.1. The amendments to the contract would affect consultants who are employed under the terms of the 2003 national contract for Consultant graded doctors in the NHS.
- 3.2. Consultants who are employed on other employment contracts who meet the eligibility criteria can apply for an award subject to agreement with the employer running the award round.

## 4. How will this the new Schedule be introduced?

- 4.1. A new Schedule will be collectively agreed as an amendment to the 2003 contract.
- 4.2. The Schedule will put in place the interim arrangements from 1 April 2018 to 31 March 2021.
- 4.3. The parties shall continue to negotiate amendments to the consultant contract, including reforms to the LCEA scheme. It is the intention of the parties to agree in negotiations that a new local performance related pay scheme will be implemented by April 2021.
- 4.4. Should collective agreement on a replacement local performance scheme not be reached, the Schedule sets out additional arrangements which will apply from 1 April 2021.

## 5. Development of the amended contract proposals

- 5.1. The proposed amendments have been developed during extensive discussions and negotiations between the parties. These have been occurring in some form since 2012 when, responding to reports from the Review Body on Doctors and Dentists Remuneration (DDRB), the Government announced its intention to seek reform of the contract for consultants. Draft heads of terms for formal talks were agreed during July 2013 and formed the basis of a mandate on which both sides sought to enter formal negotiations. During October 2013, the Government asked NHS Employers to begin negotiations with the BMA on the basis of those agreed Heads of Terms.
- 5.2. Negotiations ended during October 2014 when the BMA unilaterally withdrew from talks.
- 5.3. Government issued a remit to the DDRB to make observations on pay-related proposals for reforming the consultant's contract. The DDRB reported to the SoS during July 2015 making observations on the reform of the national consultant contract which broadly endorsed national contract reform proposals submitted in written and oral evidence to the DDRB by NHS Employers<sup>1</sup>, including on performance pay reform. The parties recommenced informal discussions, and eventually re-entered formal negotiations in September 2015 using the DDRB observations of July 2015 as the basis for further negotiations.
- 5.4. In September 2016 the BMA began legal action seeking to establish that the CEA scheme is contractual and can only be changed by collective agreement. Government position is that CEAs are not contractual and Government can make reasonable amendments to the National Scheme through a process of consultation, employers can do the same with employer based schemes.
- 5.5. Ongoing delays to contract reform and the impending legal action led both sides to enter into formal discussions to reach an interim agreement on LCEAs.

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<sup>1</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/445742/50576\\_DDRB\\_report\\_2015\\_WEB\\_book.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445742/50576_DDRB_report_2015_WEB_book.pdf)

## 6. Main amendment proposals

6.1. The main areas of change proposed are summarised below. Further commentary on potential impacts and, where relevant, justification and mitigation of these impacts is included in the next section.

6.2. Between April 2018 and March 2021 the Schedule introduces interim arrangements which will require all employers to run annual LCEA rounds with reference to the 2004 LCEA framework and the 2012 Advisory Committee on Clinical Excellence Awards (“the ACCEA”) guidance on Employer Based Awards, notwithstanding local changes made to the schemes to date. Employers will be allowed to locally agree further changes with Joint Local Negotiating Committee (“the JLNC”) agreement, for example to introduce stronger links between eligibility for awards and organisational objectives. This should encourage greater equality of opportunity amongst different groups. Supporting guidance should be made available to employers which should set out options available to them.

6.3. The following provisions shall apply:

- A requirement that any scheme must retain an internal appeals mechanism in line with existing processes or, where these do not exist, in line with the process set out in the amended 2012 ACCEA Employer-Based Award guidance;
- A requirement that a National CEA (“NCEA”) holder whose award is not renewed following application will revert to an appropriate LCEA level of between 7-8, to be determined by their NCEA renewal application score. The funding for these reversions will be from outside the 0.3 funding ratio for new LCEAs. The reversion will only apply to the applications scoring 14 or above, to ensure that renewal applications continue to be meaningful. The following reversion scoring will apply:

Score	Award level
27 or above	Level 8
14 – 26	Level 7
< 14	Award lost

- Other than in exceptional circumstances, such as an extended period of ill-health absence, if a national award holder does not submit a renewal application, there will be no reversion to LCEAs and the value of the award will be lost.

6.4. All new awards will be non-pensionable and non-consolidated with no associated uplift for Additional Programmed Activities, awarded for one year and paid as a lump sum, with the possibility of being made for a maximum of three years. From 1 April 2018 until 31 March 2021 employers will commit to an investment ratio for new awards of 0.3 CEA points per eligible consultant. This is an increase compared to a recommended 0.2 investment outlined in previous national guidance for employers published by ACCEA.

6.5. LCEAs will be retained, subject to review from 2021 for existing (pre-April 2018) award holders with the current position on the pensionable and consolidated nature of the awards maintained.

6.6. From April 2021 employers will have the flexibility to alter their LCEA scheme in consultation with their Joint Local Negotiating Committee (JLNC). However, the following must be incorporated into any new local scheme:

- The Scheme must include an appeals mechanism.
- New awards must continue to be non-pensionable and non-consolidated. Awards will be payable for a period of up to three years, paid annually by lump sum.
- The total combined value of per eligible consultant invested annually in LCEAs will remain unchanged as at 2016/17 per eligible FTE spending levels. As consultants with consolidated awards retire or lose awards, more money will be released to fund non-consolidated payments.
- LCEAs made prior to 2018 will be subject to a fair and reasonable process of review by Employer Based Award Committees or their successor using the LCEA domains and scoring system. A scoring system has been agreed by the negotiating parties which ensures that those who continue to demonstrate high levels of excellence are subject to less regular review. The following scoring system will apply:

Score	Outcome
≥ 20	Retain award(s) at current level and will not be reviewed again for five years.
16 – 19	Retain award(s) at current level and will not be reviewed again for three years.
11 – 15	Lose 1 point and reviewed again after three years.
≤ 10	Lose 2 points and reviewed again after two years.

- Previous NCEA holders who have reverted to an LCEA will have these awards reviewed three years after the anniversary of the reversion, but no earlier than April 2021.

6.7. In addition to the provisions relating to the LCEA Scheme, the schedule also includes provisions applying to the NCEA Scheme in England which confirm that consultants will continue to have access to a national reward scheme, but DHSC will have the right, after engaging in consultation, to introduce amendments and changes to the arrangements for NCEAs from and after 1st April 2019.

6.8. Where amendments and changes are introduced consultants who hold a NCEA under the current scheme as at 31 March 2019 will retain their NCEA and the associated payment will be consolidated and pensionable, subject to the 2018 ACCEA review processes.

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6.9. If a reformed national scheme is introduced after 31 March 2019 with lower value awards, consultants with an existing national award who submit a successful application under the reformed scheme will receive an additional payment so that they are paid no less overall than the cash value of the equivalent award in the current scheme. If the payment is made in the form of LCEAs it will be subject to review after 1 April 2021.

## 7. Amendments to the LCEA Scheme: impact, justification and mitigation

- 7.1. The current LCEA scheme provides consolidated local performances payments to individual consultants. The awards range in value from £3,016-£36,192 (with nine levels of local award in total) and are paid for by local employers. All awards are subject to a successful personal application rather than all consultants being considered automatically. Many consultants do not choose to put forward an application. The current awards are in most cases paid throughout a consultant's career, which restricts available funding for new awards. There is also a general expectation (if not technically a requirement) that staff progress up the scale of the award ladder over time and sequentially from lower level awards to higher value awards. This, alongside the historical make-up of the consultant workforce being predominantly male and of white British background, has resulted in the majority of higher awards being held by older white British males.
- 7.2. The LCEA system is administered locally and employers have exercised significant flexibility in its operation. Previously ACCEA provided local employers with guidance to inform how they administered the scheme and collected some local equalities data centrally from employers. ACCEA stopped publishing information on employer based local awards after 2012.
- 7.3. The last figures available, published November 2014 but covering the 2012 award round, provide details of individuals receiving local awards broken down by age, gender and ethnicity. They do not include any information regarding those achieving awards who are affected by disability. It does not include any information on the numbers of consultants applying for awards or rates of success.
- 7.4. The last ACCEA report on LCEAs shows that across all levels of awards 71.16 % of recipients were male. This compared to a gender split of 68.37% males at the time in the whole consultant population. Female consultants were more heavily weighted in the lower level of the awards - almost 63% of female local award holders held a Level 3 or lower, compared to 51% of male local award holders. At the higher levels almost 21% of male award holders held a Level 7 or above, this compared to just fewer than 12% of the female population of award holders holding the same level of award.
- 7.5. Table Y shows figures derived by NHS Digital from the Electronic Staff Records ("ESR") in September 2017. Using figures from payments made by ESR, NHS Digital have calculated that in September 2017 40% of female full-time consultants were receiving LCEAs, compared to 50% of male full-time consultants. Due to the method of deriving this data, it is not possible to state the level of awards being achieved. It is noted that in September 2017, the average payment for a full-time female consultant receiving an LCEA was £1018, whilst the average payment for a full-time male consultant receiving and LCEA was £1257. This suggests that on average men were receiving higher level awards than women. There is no corresponding data currently available in respect of male and female part-time consultants receiving LCEAs, therefore, it is not possible to draw firm conclusions regarding differences regarding the proportions of males and females accessing awards across the whole of the consultant workforce.

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- 7.6. In relation to ethnicity, ACCEA found that in the 2012 LCEA round 67% of award holders across all levels of awards were White British. The report does not provide a breakdown of the proportion of consultants of White British ethnicity in the consultant workforce, however, the figures from 2017 in Table V below show the figure to be 58.3%. In 2012, almost 50% of BME local award holders had an award of Level 1 or Level 2, compared to less than 40% of white award holders (incorporating White British and White Other ethnicities). Just over 30% of white award holders held a Level 7 or above compared to less than 20% of BME award holders.
- 7.7. In relation to age, the figures show that Level 9 awards are most likely to be held by individuals aged around 57. Holders of Level 1 to 3 awards peak between the ages of 45 and 48. The overall pattern shows that the highest level awards tend to be held by older consultants.
- 7.8. Table Y below also shows that in September 2017 the percentage of both male and female full-time staff receiving LCEA payments gradually increases with age peaking at age 55 to 59, before then declining. The average payments received by both males and females, on the whole increase with age, with the exception of the slight decline for males over the age of 65.
- 7.9. In 2015 the (then named) Department of Health undertook a triennial review of ACCEA. The review noted evidence from stakeholders which suggested that the 'self-nomination' (application) element of the CEA process was a potential barrier to women and/or BME consultants. Although this comment was made with reference to the national scheme, it is worth noting that awards under the existing LCEA scheme are also made by application and are likely to be impacted by similar dynamics. Under the proposed amendments the LCEA scheme will retain the current system of application, however local employers will be able to make amendments with the agreement of the JLNC should they see a requirement to redress any apparent inequalities resulting from the application process. This allows scope for local employers to consider means of encouraging and supporting a greater proportion of female and BME consultants to apply for awards and ensure these are at an appropriate level.
- 7.10. The purpose of the interim agreement is to allow for limited revisions to the current Scheme whilst wider negotiations regarding the terms of the consultant contract continue. As such, the Schedule can be seen as a route towards collectively agreeing further amendments to the contract which will aim to reward all consultants fairly and equally.
- 7.11. The current LCEA scheme, where awards are not time limited, ties up the bulk of spend on LCEA in long term effectively consolidated payments. As noted above, awards are often made at a much higher level for those with longer service.
- 7.12. The proposed principles underpinning the amended Schedule would move towards removing the apparent link between long service and higher level of awards. As new awards are for a maximum of three years, they will be based on achieving excellence within a recent timeframe. Future awards will only be renewed where consultants can demonstrate ongoing and continuing excellence. This should contribute towards the removal of any indirect age discrimination linked to the long term consolidated nature of the current scheme. This will also make the system fairer for the younger consultant workforce, where there are more females and people from BME backgrounds (see tables below), as they will be able to achieve higher level awards if they are excellent performers as opposed to higher awards being linked to time served at the consultant grade.

- 7.13. Consideration has been given to any impact on those who may be absent for long periods, such as those taking maternity or parental leave and those who are affected by disability or long-term sickness. An approach based on annual performance assessment might make it difficult for such staff to provide evidence that they have achieved excellence against their annual objectives. However, this does not represent a change to the current system. Local employers can exercise discretion and make locally agreed amendments to the scheme in order to avoid any detrimental effects and support those who demonstrate excellence but may find it difficult to apply for awards due to their circumstances.
- 7.14. Once they return to work after career breaks taking care of children or after long periods of illness, there would be benefits associated to the proposals for these groups. This is due to the fact that under the amendments there will be improved access to awards for those who have served less time as consultants. The intention is for awards to have a stronger link to demonstrating current excellence, as opposed to a long-service record of experience and excellence and this will be of benefit to those who take career breaks.
- 7.15. Under the proposed amendments existing LCEAs will become subject to review five years after the date of the award of the consultant's last Existing LCEA point. However, the duration of any review period will take into account time taken for maternity/paternity/adoption leave or an extended period of absence such as ill-health absence, subject to the arrangements outlined in the amended 2012 ACCEA Employer-Based Award guidance. This will ensure that those who are absent for long periods are not disadvantaged by the introduction of a review process.
- 7.16. The proposals acknowledge that there needs to be protection for those who hold awards in the current scheme, and strike a balance between the interests of these individuals and those who have little or no stake in the current scheme.
- 7.17. A new feature which will be introduced with these amendments will be a reversion to an LCEA for those who unsuccessfully apply to renew an NCEA. Under the current scheme, individuals who are unsuccessful in their application to renew an NCEA lose all CEA income, subject to the discretion of their employer. An individual who unsuccessfully applies to renew a Bronze national CEA can stand to lose £36,192 from their income in a year. There is no data available regarding the number of employers applying discretion to offer LCEAs to those who unsuccessfully apply to renew NCEAs.
- 7.18. Data from the ACCEA Annual Report 2016 shows that 82 consultants failed to provide evidence to justify continuation of their award and their awards were withdrawn. The large majority of unsuccessful renewals were at Bronze level. The report shows that 74% of Bronze award holders were white, 72.3% were male and the mean age was just over 51<sup>2</sup>. However, it does not provide data regarding any protected characteristics of the individuals who unsuccessfully applied to renew NCEAs. Due to a lack of data, this amendment cannot be said with any certainty to benefit any group in particular.
- 7.19. Under the proposed amendments to the LCEA scheme, an NCEA holder who is unsuccessful in their application to renew will revert to an LCEA level 7 or 8, dependent on their NCEA renewal score. Those scoring 27 or above in their renewal application will revert to a Level 8 LCEA and those between 14 and 26 to a Level 7. This is to ensure there remains a distinction between different levels of achievement. To benefit from this

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<sup>2</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/671213/ACCEA\\_Annual\\_Report\\_2016.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/671213/ACCEA_Annual_Report_2016.pdf)

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reversion the NCEA renewal application must score 14 or above. This provision is to prevent renewal applications which are not meaningful benefitting from the LCEA reversion. Between 1 April 2018 and 31 March 2021 these reversions will be funded outside of the 0.3 per FTE funding ratio and, as such, consultants eligible for new LCEAs will not be disadvantaged by this arrangement. Further, the awards will be reviewed three years after the anniversary of their reversion on an ongoing basis to ensure that local excellence is being demonstrated to warrant a continuing local award. This duration of this review process should time taken for maternity/paternity/adoption leave or an extended period of absence such as ill-health absence, subject to the arrangements outlined in the amended 2012 ACCEA Employer-Based Award guidance.

- 7.20. Under the current schemes consultants are not able to hold both local and national awards. This new provision ensures that those who are unsuccessful in their application to renew a national award, but are still demonstrating excellence to an appropriate level, are provided with some equivalency under the local scheme. The amendment offers a degree of stability which can be important to support the retention and engagement of often highly experienced consultants. It helps to ensure that experienced consultants remain invested in the CEA scheme and in demonstrating and evidencing excellence.
- 7.21. It is noted that, where an individual who has an NCEA struggles to evidence their renewal application due to time away from practice, for example due to maternity or long-term ill health due to disability, they would also benefit from this reversion mechanism.
- 7.22. Until the end of March 2021, the minimum investment ratio for new LCEAs will be 0.3 points per eligible consultant annually. The funding cannot be deferred and must be awarded in that year, unless there is agreement from the JLNC to carry forward uncommitted funds to be spent in the next year. This guaranteed funding for new awards represents an improvement on the current system where funding is often tied into long-standing consolidated awards. This change will ensure that awards are more accessible to those who have previously not had awards, such as younger consultants.
- 7.23. Following the introduction of the new Schedule, new LCEA points will no longer be pensionable. The key benefit in making new awards non-pensionable is that any savings from associated employer contributions will be recycled into the cost envelope. This will contribute to the funding available for new awards and improve access for a wider number and range of consultants, including those who are women, are from BME backgrounds or who have a disability.
- 7.24. As noted above, the aim is for agreement to be reached on a new consultant contract in due course. It is the intention of the parties to agree in negotiations that a new local performance related pay scheme will be implemented by April 2021. As set out above, equality analysis will continue to ensure that future proposals meet the PSED. Any current remaining unintentional differential impact relating to this Schedule changing the LCEA scheme should be considered in the context of the intended future changes to the wider package of contract reform.
- 7.25. Should agreement not be reached by April 2021, local variations may be introduced to the LCEA scheme in consultation with the JLNC. This will allow local employers further flexibility to consider changes that can be made to the scheme to improve equity of access to awards where any differentials remain and this is encouraged. Post April 2021, LCEAs made prior to April 2018 will be subject to a fair and reasonable process of review. This will ensure that those holding LCEAs continue to

demonstrate current excellence. This should reduce any risk of indirect age discrimination and ensure consultants at all stages of their careers have the opportunity to demonstrate excellence to achieve the higher level awards.

- 7.26. In relation to the NCEA scheme, the agreement will clarify that DHSC has the right, after engaging in consultation, to introduce amendments for NCEAs from 1 April 2019. However, the proposed Schedule sets out provisions whereby any consultant with an existing NCEA receiving an award under a reformed national scheme with lower value awards, would receive an additional payment to ensure that they are paid no less overall than the equivalent award in the current scheme. The additional payments will be in the form of LCEAs which will be subject to review, to ensure that local excellence is being demonstrated over time. This provision will be of benefit to those who currently hold NCEAs, who according to the 2016 ACCEA Annual Report are more likely to be male, white and over the age of 50. However, the additional payments would not be of detriment to those applying for LCEAs or awards under a new national scheme, as the costs will be met by reallocation of the previous NCEA funding mechanism. It will also help to ensure that this group of consultants remain invested in demonstrating and evidencing excellence at a national and regional level.
- 7.27. Overall, the proposed amendments take a significant step towards advancing equality of opportunity by increasing access to awards for all consultants. This is achieved by guaranteeing funding for new awards and ensuring that new awards are time limited, whilst simultaneously introducing review mechanisms for awards which have previously been awarded. The encouragement of local employers to agree changes to LCEA schemes to support any under-represented groups to apply for awards further improves equality of access and opportunity.
- 7.28. The amendments help to foster good relations between persons who share relevant characteristics and those who do not by encouraging equality of access and opening up more opportunity to apply for awards. The encouragement of local employers to be transparent in regards to publishing data relating to those achieving awards should help to foster good relations by opening award schemes up to scrutiny and challenge where awards are not seen to be distributed fairly. This should result in wider support to agree local changes which positively impact on equalities.

## 8. Addressing the impact on equalities – by protected group

### Gender and pregnancy/maternity

- 8.1. As shown in Table V in Annex B, the majority of consultants are male (64.4%). Table X shows that the gender split is almost equal in the 25-29 and 30-34 age bands; however, the proportion of male consultants gradually increases with age. Table X also shows that 68.3% of female consultants are under the age of 50 compared to 55.23% of male consultants. The female consultant workforce is, on the whole, younger than the male consultant workforce and more likely to work part-time. Table Y shows that 32.5% of female consultants work part-time compared to 11.5% of male consultants. They are also more likely to take time out from employment to care for children or other dependents.
- 8.2. Table Y below suggests that that 40% of female full-time consultants were in receipt of payments for LCEAs in September 2017, compared to 50% of males. A higher proportion of men were in receipt of LCEAs across all age bands until age 55 to 59 when the proportions were equal, the trend is reversed over the age of 60 and a greater proportion of the full-time female consultant workforce were in receipt of LCEAs than in the full-time male consultant workforce.
- 8.3. In the month of September 2017, the average LCEA payment for full-time women was £1018, compared to £1257 for full-time men. At every age band apart from 65 and over, full-time women receiving an LCEA received a smaller average payment than full-time men receiving an LCEA. The guaranteed investment in new LCEAs between April 2018 and March 2021 offers opportunity for women to access new awards and begin to redress the current difference in average earnings between male and female consultants. This will also require support from local employers who can use the flexibilities available to them to assist and encourage applications from those who are under-represented.
- 8.4. As shown in Table W below, 32.5% of female consultants work part time in comparison to 11.5% of male consultants. There is no available data with regards to the proportion of LCEA holders who work part-time and it cannot be said whether working pattern affects the likelihood of holding an award. The proposed amendments do not make any changes to the scheme which would make it more difficult for part time workers to apply for awards or to demonstrate excellence. Local employers must also comply with their own PSED in relation to their LCEA schemes. Encouraging local employers to collect and publish equalities data on those being awarded LCEAs will enable a greater understanding of whether part-time workers are currently under-represented. Further work can then be undertaken locally to alleviate any unequal access.
- 8.5. Those who choose to take long periods of maternity, parental leave, or similar may not be able to provide evidence to show they have achieved recent excellence. In this respect, the amendments make no changes to the current system. However, under the proposed amendments local employers will now have the opportunity to agree amendments to the scheme if they wish to support those taking or returning from extended leave to apply for awards. The amendments to the LCEA scheme offer a

benefit to those who take extended leave from their role, as on return to work there is more opportunity to access awards, with reference to investment during the initial period, introduction of non-consolidated payments, and (from April 2021 unless further agreement is reached) link to per FTE funding. There is also a further benefit to these individuals on return from extended leave associated to the stronger link with demonstrating current excellence as opposed to long-service excellence. The review mechanisms will also include provisions to take into account extended periods of absence due to maternity/paternity or adoption leave.

- 8.6. In summary, the amendments to the LCEA scheme are a route to achieving wider contract reform in future to ensure all consultants are rewarded equitably. The changes ensure guaranteed funding for new awards which should improve accessibility for younger female consultants who have previously not held awards. A current link between LCEA earnings and time served as a consultant will be diminished, which will be of benefit to women who have taken time out of their careers, for example due to maternity or other caring responsibilities. Within the amendments to the LCEA scheme there is also scope for local employers to engage in work to introduce features to reduce any unintentional disproportionate impact on women, for example, by encouraging and supporting more women to apply for awards of the correct level and offering support with the application process. Such actions are encouraged.

## Disability

- 8.7. Table V in Annex B gives a breakdown of the consultant workforce by disability status. A very small proportion of consultants are recorded as having a disability – 0.8%, although it is noted that almost 40% of consultants have not provided any information as to whether they are affected by a disability. Firm assumptions cannot be drawn from the available data regarding the proportion of the consultant workforce affected by a disability.
- 8.8. The ACCEA 2012 Annual Report did not provide a breakdown of how many local award recipients were recorded as having a disability and there is no other source of data which records this. As such it cannot be said whether a proportionate number of disabled individuals hold local CEA awards.
- 8.9. Those with a disability may be more likely to be absent from the workplace due to sickness, potentially long-term, and as a result would find it more difficult to evidence excellence. However, the proposals to amend the scheme make no changes to the means of applying for awards and therefore the proposed amendments have no impact. If those with a disability are experiencing difficulty in evidencing local excellence then local employers may use their flexibilities to agree amendments to the scheme to support applications from disabled consultants. Furthermore, those who experience periods of long-term absence would benefit from the diminished link between awards and time served as a consultant. The review mechanisms will also include provisions to take into account extended periods of absence due to ill-health.
- 8.10. It is also possible that those affected by a disability are more likely to work part-time. The conclusions drawn in Paragraph 8.4 regarding female part-time workers are also applicable to disabled part-time workers.
- 8.11. In summary, accurate data regarding the number of disabled consultants or those holding LCEAs is not available. It is not considered that the proposed amendments will limit the scope of consultants who are affected by a disability to achieve awards. As

noted throughout this assessment there will be local flexibility to make changes to the scheme to reduce any disproportionate impact where it is identified.

## Race

- 8.12. Table V gives a breakdown of the Consultant and doctors in training workforce by ethnic group. It is noted that amongst those in medical training there is a higher proportion from BME backgrounds, suggesting that younger consultants are more likely to be from diverse ethnic backgrounds.
- 8.13. The percentages of consultants from BME backgrounds holding various levels of local CEAs in 2012 are noted above. The amendments do not propose any changes to the process of applying for LCEAs; however, scope is introduced for local amendments to be agreed. Such amendments could focus on supporting BME applicants to apply for LCEAs.
- 8.14. Under the proposals the guaranteed funding for new awards will be of benefit to those who do not currently hold awards, more likely to be younger consultants and from BME backgrounds. Consultants will be able to achieve awards based on recent evidence of excellence as opposed to there being an indirect link between awards and time served as a consultant.

## Age

- 8.15. As discussed above, currently older consultants are more likely to hold a higher level of award. This is not necessarily as a result of discriminatory practice and may simply reflect the fact that those with more experience are displaying excellence which is eligible for award due to increasing competence throughout their career and that it takes time to climb the scale of awards. However, the changes proposed whereby points are non-consolidated and subject to review, mean that time served as a consultant will no longer be as much of a determining factor in the achievement of the highest value payments. This will be of benefit to younger consultants.
- 8.16. As noted above, younger consultants are more likely to be female and from BME backgrounds. The benefits of the amendments to these groups, set out above in this document, also apply to all consultants from younger age bands.
- 8.17. Table Z shows that consultants within the age ranges of 35 to 54 are equally likely to work part time, with around 16% of consultants in each of these four age bands working part time. However, those aged 25-29 are significantly more likely to work part time, with 37.5% of consultants in this age band working part time. Due to the small numbers of individuals in this age band, it cannot be said whether this is an anomaly. However, if younger consultants are more likely to work part-time, it is not considered that the proposed amendments to the LCEA scheme will have an adverse effect on the ability of these individuals to apply for an award of demonstrate excellence.
- 8.18. In summary, the proposed amendments will be of benefit to younger consultants due to the non-consolidated nature of new awards and the guaranteed funding available.

## **Gender reassignment: including transgender**

8.19. There is no data available on this category. We do not envisage any significant impact on this protected characteristic.

## **Sexual orientation**

8.20. Table V in Annex B gives a breakdown of the consultant and doctors in training workforce by sexual orientation. We do not envisage any significant impact on this protected characteristic.

## **Religion or belief**

8.21. Table V in Annex B gives a breakdown of the doctor workforce by religious belief. Our assessment is that the amendments in relation to local CEAs will not differentially impact individuals according to their religious beliefs.

## 9. Conclusions

9.1. As set out in Paragraph 2.2 above, the key objectives informing the negotiations between NHS Employers, BMA and HCSA in relation to amendments to the LCEA scheme were to ensure fair distribution of awards based on the assessment of current excellence, clarify employer's flexibility to bring in local changes and gain commitment from employers to guarantee funding for awards. The proposed changes meet these objectives and help to bring about positive impacts on equalities whereby new awards are funded, time limited and subject to review, opening up more opportunity to access awards to those who have not previously held awards such a female consultants, those from BME backgrounds and younger consultants. Employers are encouraged to use local flexibilities to agree changes to schemes to further support under-represented groups to apply for awards, thus bringing about further positive impacts on equalities.

## 10. Further work to assess equalities impact of the contract amendment

10.1. As set out above, this is a forward-looking analysis of the expected equalities impacts of the amended contract proposals in specific relation to the local CEA scheme.

10.2. The proposed amendments are seen as a route towards achieving a more equitable performance related pay scheme which is based on assessment of current excellence. This in itself is an important step to achieving wider contract reform focused on rewarding the consultant workforce equitably. It is not considered that the amendments have any direct or indirect adverse effect on people with protected characteristics. We also consider that the new amendments give scope to local employers to introduce provisions which could reduce any potential unintended differential impacts of the previous arrangements on those with protected characteristics. Guidance should be made available to employers setting out available options and employers will be encouraged to publish equalities data relating to those receiving awards which can be used to feed into future developments and amendments.

## 11. Next steps

- 11.1. NHS Employers will continue to work with the service to prepare the potential introduction of this proposed amended contract. The DDRB will continue to make annual recommendations to government on pay levels for Doctors, taking account of evidence from all parties.

# Annex A

## Public sector equality duty in the Equality Act 2010

### 149 Public sector equality duty

- (1) A public authority must, in the exercise of its functions, have due regard to the need to:
- (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
  - (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
  - (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
- (2) A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).
- (3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
- (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
  - (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
  - (c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.
- (4) The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.
- (5) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
- (a) tackle prejudice, and
  - (b) promote understanding.
- (6) Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.
- (7) The relevant protected characteristics are—
- age;
  - disability;
  - gender reassignment;

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pregnancy and maternity;

race;

religion or belief;

sex;

sexual orientation.

(8) A reference to conduct that is prohibited by or under this Act includes a reference to—

(a) a breach of an equality clause or rule;

(b) a breach of a non-discrimination rule.

(9) Schedule 18 (exceptions) has effect.

# Annex B

## Evidence

1. The main source of data on the characteristics of the Consultant and Doctors and Dentists in training workforces is the Electronic Staff Record System (ESR), the payroll and human resources system used by all but two NHS trusts. ESR informs workforce publications by the Health and Social Care Information Centre (HSCIC) (also known as NHS Digital) and can also inform supplementary analyses beyond the scope of those publications.
2. Across their publications, HSCIC data is available on the distribution of the Doctor workforce across many of the protected characteristics. Table V below summarises the latest available information. This is supplemented by tables X, Y and Z, which also set out part-time working rates by gender and age range.
3. Assessments of any potential differential impact of the new contract across equality dimensions are largely qualitative.

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Table V: Proportion of Doctor Workforce by Various Equality Dimensions, September 2017

Sep-17	Consultant (including Directors of Public Health)	Specialty Registrar	Core Medical Training
<b>DISABILITY</b>			
Disabled	0.8%	1.2%	1.3%
Not Disabled	59.6%	78.1%	82.1%
Not Disclosed	19.9%	11.9%	8.6%
Unknown	19.8%	8.8%	8.0%
<b>ETHNICITY</b>			
White	58.3%	49.6%	49.2%
Black or Black British	2.7%	4.7%	4.8%
Asian or Asian British	26.3%	25.2%	24.8%
Mixed	2.0%	3.4%	3.9%
Chinese	1.8%	3.0%	3.2%
Any Other Ethnic Group	3.1%	3.9%	3.8%
Discontinued codes	0.1%	0.0%	0.0%
Not stated	5.0%	6.8%	6.1%
Unknown	0.7%	3.4%	4.2%
<b>GENDER</b>			
Female	35.6%	53.0%	51.5%
Male	64.4%	47.0%	48.5%
<b>RELIGIOUS BELIEF</b>			
Atheism	7.3%	13.8%	19.1%
Buddhism	0.8%	1.5%	2.0%
Christianity	23.1%	26.8%	23.0%
Hinduism	8.7%	7.8%	6.8%
Islam	5.4%	11.8%	12.8%
Jainism	0.2%	0.2%	0.1%
Judaism	0.6%	0.7%	0.5%
Sikhism	0.6%	1.0%	1.0%
Other	2.1%	3.0%	3.8%
I do not wish to disclose my religion/belief	31.8%	25.9%	24.0%
Unknown	19.2%	7.4%	6.9%
<b>SEXUAL ORIENTATION</b>			
Heterosexual	49.4%	68.1%	71.5%
Gay	0.6%	1.1%	1.5%
Lesbian	0.1%	0.3%	0.3%
Bisexual	0.2%	0.4%	0.5%
I do not wish to disclose my sexual orientation	30.2%	23.0%	19.8%
Unknown	19.4%	7.2%	6.3%
<b>AGE BAND</b>			
Under 25	0.0%	0.1%	1.5%
25 to 34	1.8%	62.3%	83.6%

35 to 44	36.5%	33.2%	12.5%
45 to 54	40.1%	4.0%	2.1%
55 to 64	18.8%	0.4%	0.3%
65 and Over	2.7%	0.0%	0.0%

Source: Derived from Hospital and Community Health Services Workforce Statistics: Equality and Diversity in NHS Trusts and CCGs in England, September 2017

**Table W: Doctor Staff by Gender and Contract, September 2017**

Sep-17	Consultant (including Directors of Public Health)	Specialty Registrar	Core Medical Training
Proportion of Males:			
Full time	88.4%	96.92%	98.33%
Part time	11.5%	3.07%	1.66%
Proportion of Females:			
Full time	67.40%	77.30%	91.28%
Part time	32.50%	22.69%	8.72%

Source: Derived from Hospital and Community Health Services Workforce Statistics: HCHS Doctors staff by gender and contract, in NHS Trusts and CCGs in England, as at 30 September 2017

**Table X: Consultants (including Directors of Public Health) by Age Band and Gender, September 2017**

	Male	Female	Male	Female
25 to 29	50%	50%	0.01%	0.02%
30 to 34	49%	51%	1.38%	2.60%
35 to 39	55%	45%	11.46%	17.32%
40 to 44	61%	39%	21.57%	25.37%
45 to 49	62%	38%	20.81%	22.99%
50 to 54	66%	34%	19.00%	17.71%
55 to 59	74%	26%	14.39%	9.17%
60 to 64	79%	21%	7.75%	3.68%
65 and over	85%	15%	3.61%	1.12%

Source: Derived from Hospital and Community Health Services Workforce Statistics: HCHS Doctors staff by age band and gender, in NHS Trusts and CCGs, as at 30 September 2017

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**Table Y: Full Time Consultants by age band and gender receiving CEAs in the month of September 2017**

	All Ages	25-34	35-39	40-44	45-49	50-54	55-59	60-64	65 and over
Average payment for Female Full time Consultants receiving a Clinical Excellence Award	£1018	£0	£350	£512	£777	£1137	£1507	£1681	£2008
Average payment for Male Full time Consultants receiving a Clinical Excellence Award	£1257	£419	£391	£627	£946	£1424	£1751	£1897	£1744

% of Female Full time Consultants that received a Clinical Excellence Award in Sept 2017	40%	0%	6%	25%	48%	64%	73%	64%	44%
% of Male Full time Consultants that received a Clinical Excellence Award in Sept 2017	50%	2%	12%	32%	57%	71%	73%	58%	37%

**Source: Derived from NHS Hospital and Community Health Services: Full time consultants in England and those receiving Clinical Excellence Awards by gender and age band in the month of September 2017**

Notes:

Full time is defined as those staff with a full time equivalent between 0.99 and 1.01.

Figures in the table are provisional NHS Staff Earnings estimates.

As expected with provisional data, some figures may be revised prior to the next publication as issues are uncovered and resolved.

Figures rounded to the nearest pound.

These figures represent payments made using the Electronic Staff Record (ESR) system to NHS Staff who are employed and directly paid by NHS organisations.

Figures based on data from all English NHS organisations who are using ESR (Two Foundation Trusts do not use ESR).

Figures are based on staff with contracted hours more than zero. Bank and locum staff that typically have no contracted hours are not included in these figures.

The sample sizes quoted do not represent the true number of contracted staff in each group.

Please see published Staff in Post figures.

**Table Z: Consultants (including Directors of Public Health) by Age Band and Contract, September 2017**

	Part Time	Full Time	Part Time
25 to 29	0.03%	62.50%	37.50%
30 to 34	1.16%	87.88%	12.12%
35 to 39	11.90%	83.30%	16.70%
40 to 44	19.88%	83.51%	16.49%
45 to 49	18.26%	83.91%	16.09%
50 to 54	16.05%	83.54%	16.46%
55 to 59	12.06%	81.69%	18.31%
60 to 64	12.61%	61.93%	38.07%
65 and over	8.03%	44.00%	56.00%
Total	99.98%		

**Source: Derived from Hospital and Community Health Services Workforce Statistics: by age band and contract, in NHS Trusts and CCGs, as at 30 September 2017**

## Annex C

### Engagement and involvement

- 1) We have engaged stakeholders in gathering evidence or testing the evidence available:
  - representation of staff side (trade unions) and management side (NHS employing organisations) through negotiating teams. Development and discussion of proposals in discussion papers, presentations, and draft schedules of terms and conditions;
  - use of wider reference group of employers to inform negotiations
  - the BMA and HCSA used their own wider structures
  - commissioning an independent review by the DDRB in 2011 and again in 2014, with any party free to submit evidence to that review and with all evidence and the DDRB's report being published. This was an open and transparent process, with all parties (who responded to the DDRB's call for evidence) publishing their evidence and free to comment on evidence submitted by others; and
- 2) This engagement has involved the following groups:
  - In negotiations: Doctors were represented by the BMA and HCSA; employers were represented by NHSE and employer representatives;
- 3) The key outcome from these activities is that the views of Doctors, through their representative body and the views of independent pay review bodies, have informed amendment to the contract, mainly through negotiations with the BMA and HCSA.