

Reforming National Clinical Excellence Awards

Submission from the Academy of Medical Royal Colleges

June / 2021

Introduction

The Academy of Medical Royal Colleges [“the Academy”] is the umbrella organisation for all the medical royal colleges and faculties in the UK. Individual Colleges and Faculties may well choose to make their own responses to the consultation, but this response incorporates comments from our member organisations and has been endorsed by all our members. It should therefore be seen as representing the views of all medical royal colleges and faculties.

Broadening access to the scheme. Number of NCEAs

- *Do you agree or disagree that the number of available CEAs should be increased so that 1% of the eligible clinician population could hold a platinum award; 2% a gold award and 3% silver award?*
- *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?*
- *Do you agree or disagree with the proposed award levels in light that there is no local CEA (LCEA) scheme in Wales?*
- *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?*
- *What alternative scheme would you like to see in place?*

Yes, making the awards more widely available is a positive objective. Clearly increasing the availability of the awards would also be achieved through increasing the available funding.

We have no specific comments on the number of awards available at each level. However, the new arrangements do quite significantly alter the balance of awards.

Currently the ratio of awards [excluding Bronze awards] for both holders and applicants is roughly: Silver, 65%; Gold, 25% and Platinum, 9%.

According to the consultation document, under the new arrangements the proposed split would be: Silver, 50%; Gold, 33% and Platinum 17%.

The Academy is not saying this is intrinsically better or worse, but it is important to recognise the change.

Wales

We have not had specific responses from member organisations on the Wales-only questions and do not therefore wish to make detailed comments on these. However, it does seem important that the Bronze award is retained in the absence of local awards.



The inability to hold a local and national award does mean that the value of awards for future national CEA holders is dramatically reduced. This may have a long-term impact on the ability to retain very senior clinicians in Wales.

Local performance awards and NCEAs

- *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? The national bronze award would be scrapped.*

Value of awards

We welcome the fact that individuals will be eligible for both local and national awards. For those achieving this the value of awards will obviously therefore be higher. However, the fact remains that the value of the awards is around half the previous level (more for the silver awards).

Does ACCEA know what proportion of national award applicants work solely at national level (and so would not be eligible for a local/regional award) and what proportion are involved in local work and thus eligible for local/regional awards?

The application of local awards is more variable and even if the majority of applicants will be eligible for local as well as national awards there is likely to be inconsistency of treatment of individuals making similar contributions.

We presume that the value of awards for existing award holders would be protected and individuals will not see their current payments reduced. However, this does need to be made explicit.

The consultation recognises that the skills of these senior doctors are “*valuable and sought-after both nationally and internationally*” and therefore “*it is important to retain these experts’ skills and knowledge*”. Halving the value of the awards will do nothing to aid that retention effort. The monetary value of the awards was never likely to match international or private sector remuneration but reducing them so substantially exacerbates the position, reduces the psychological value as well as the monetary value of the awards and sends the wrong message in terms of valuing the national and international contribution of senior doctors.

Bronze awards

Aside from enabling more awards to be made within the funding envelope, we do not understand the rationale for the scrapping of the Bronze level award.

It would seem that the consequence is that either the standard for the other national awards will reduce to accommodate those previously receiving Bronze awards or, if the bar remains the same, it will become a bigger jump to first enter the national awards pool and you will reduce the range of those eligible for national awards.

Members have also stated that it could potentially have an adverse effect on the smaller specialities.

There is an important and serious consideration for Academic General Practice which is not currently eligible for local award schemes at all, so by removing the entry point to awards, it is going to further widen their inequality gap (see Additional Comments below). This would not be an issue if a local scheme for Academic GPs was re-introduced (it stopped in 2013).

Process

We remain very unclear as to the proposed process for considering national awards and Colleges also made this point.

The two paragraphs “*We propose that applicants...*” and “*This change is expected...*” in the “*Broadening access to the scheme*” section suggest that a regional scoring process would determine whether applicants have reached the required standard for an award and, if so, the level of that award. In terms of platinum awards, it is said that twice the number of top-scoring



applications will be drawn proportionately from each regional pool and then re-scored by a platinum committee.

It is unclear whether this process would run in place of or alongside the current process conducted by Colleges and the Academy.

Colleges currently make national nominations and the Academy co-ordinates and scores College platinum applications for submission to ACCEA. Clarity over whether this process will continue or not is obviously crucial for Colleges.

We believe that Colleges do have a key role to play and are in the right position to make judgements about the value of national contributions of clinicians across the proposed domains. We believe Colleges should continue to be able to make nominations.

Changes to the domains for assessing national CEA applications

- *Do you agree or disagree with these modified domains?*
- *What domains would you like to see and why, and/or how would you modify the descriptors provided for the proposed 5 domains?*

We are broadly supportive of the proposal on the domains. We would make the following specific points

- We suggest adding 'management' to the leadership domain. i.e. 'leadership and/or management'
- The innovation/research domain appears to emphasise innovation and service rather than other fields of research. We question how this will impact on the recognition of research in these other areas
- It is important that across all the domains, including Domain 5, relevant work for medical royal colleges and other recognised professional bodies that benefits the NHS is acknowledged and recognised.
- Whilst the "Other" domain is useful, comparative scoring is going to be more difficult for what might be very divergent work. ACCEA is going to have to give strong and clear guidance on criteria and eligibility for this domain for applicants and for those scoring.
- We had comments from a lay representative about the need to highlight evidence of impact on improved outcomes for patients/carers/citizens. That is both within each of the domains and even potentially in a fifth domain solely dedicated to improving outcomes for patients/carers/citizens. Our submission to the ACCEA triennial review in 2015 suggested inclusion of a special section to collect information on contributions made at a national and international level to improve the care of patients.

The question has been raised whether there should be an expectation that all domains are completed or whether it should be, for example, any four domains or "Developing and delivering your service domain" (to maintain the focus on improvements for service) plus any 2 or 3 others. The rationale for this is that not all staff will operate across all domains and LTFT or staff in DGHS with fewer research opportunities may be disadvantaged by an expectation to complete all domains. As such, we support the 4-domains out of 5 proposal.

Improving access to the national clinical excellence awards

- *Do you agree or disagree with our proposals for improving access to the NCEA competition?*
- *Do you have suggestions on how we can improve access to the scheme for women and those with protected characteristics?*
- *How far do you agree that those working LTFT should be in receipt of the full award values as opposed to the current pro-rated award payment?*



Colleges and the Academy fully support ensuring the widest possible access to the awards.

We welcome the work that ACCEA has done over recent years in ensuring transparency in the awards process. We recognise that the allocation of awards is proportionate to applications in terms of gender although there remains a gap in terms of ethnicity.

We note the recommendations concerning gender equality and CEAs in Professor Dame Jane Dacre's report on the gender pay gap in medicine. We look forward to working with stakeholders to help improve access, recognising that many of the actions require a whole system approach, bringing together Government, employers, medical schools, the medical Royal Colleges and others.

As is recognised a problem remains in attracting sufficient applications in the first place by female and minority ethnic applicants. It will be really important that proposals (e.g. encouraging flexible working for men and women) do not result in fewer opportunities and therefore less chance of a successful CEA application from women and those with protected characteristics. The Academy and Colleges will support national activity to address this issue and themselves have a role they can play. It may be that Colleges need to set themselves targets, such as the proportion of applications from one or another group to aim for.

Whilst Colleges or other professional bodies will do what they can from a national level, it is the action of employers in directly encouraging applications from suitable individuals in underrepresented groups that will have the greatest effect.

But the exploration should begin by asking underrepresented groups why they don't currently apply and this is research which ACCEA could undertake or commission.

We support the proposal that future NCEA awards should not be paid on a pro-rated basis but instead be paid at the full-award value. NCEAs are a recognition for the level of achievement. The criteria for attainment are not modified for pro-rata working. Individuals who do work part time will potentially have had to achieve a relatively higher level of success to be granted an award – to then reduce it would be inappropriate.

Maintaining excellence during the period covered by a CEA

- *Do you agree or disagree that this is an appropriate way of incentivising the maintaining of excellence during the period covered by a CEA?*
- *What proposals do you have to ensure CEA holders maintain clinical excellence throughout the time they hold the award?*

Whilst the intention behind the proposal is perfectly understandable, we do not believe it is practical or robust.

Predicting plans is always hard – the pandemic illustrates this perfectly. No application in 2019 would have accounted for COVID-19 but it probably has impacted the work of every applicant.

It may be possible to encourage applicants to set out how they see the work in the particular domains continuing but scoring has to be based on achievement and outcomes not intention. The awards are recognition for assessed work done but spread over the next five-year period. They should not be rewards for anticipated future intentions.

The consultation states that any future intentions statements are not meant to influence scoring although it is hard to see that they wouldn't to some extent; so, if it is not intended to do that, why have the statement at all?

Stating that it is expected that work and achievements will continue is easy to do and hard to prove without retrospective checking with the danger that it becomes a somewhat meaningless exercise.



An ending to the renewals process

- *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?*

We support the retention of the five-year period.

We fully support the principle that any renewal or further application from a clinician should be expected to meet the same standards and criteria as a new application.

As the consultation recognises, under the present scheme the procedure for applying to renew a national CEA is essentially identical to the process for making an application for a new award. Therefore, whether clinicians formally make a new application or a renewal seems immaterial.

The pensionable status of NCEAs

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

There are differing views on this issue with people both in favour and opposed to awards being non-pensionable.

On the one hand, if awards remain pensionable, there is a real concern that it will encourage those with large NHS pension 'pots' already and who are over the age of 55 to leave the NHS. It will be financially better to retire rather than renew and see a large drop in pensionable salary. For younger members it may encourage them to leave the NHS Pension scheme prematurely.

On the other hand, it is argued that making future NCEAs non-pensionable will significantly reduce the overall value of these awards and result in problems for existing award holders who potentially will not receive pension benefits on which they have paid contributions and annual allowance taxation on. Even if some protection of pensionable pay is offered this will be extremely problematic as younger members who may expect to see their basic pay rise through incremental pay progression.

We presume that any change to pensionable status would only apply prospectively to new awards and not to existing award holders.

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

- *Do you support the changes proposed for the role of employers?*
- *Do you have any other comments on the role that employers should take in a new national award process?*
- *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?*
- *What criteria should determine whether an NNB or SS should be accredited?*
- *How far do you support the changes proposed for third-party citations?*

Employer role

If employers are scoring applications they are, in effect ranking. Removing this requirement does not seem to make much difference in practical terms. It simply means not putting scored applications in ranked order.

We agree that employers have an important role in validating applicants' suitability for national awards, given governance and appraisal structures. Employers are also best placed to encourage applicants from underrepresented groups.



Identifying accredited nominating bodies

We recognise that it is important that there should not be disproportionate representation of any specialty or subspecialty simply because of the number of nominating bodies in that field.

However, individual clinicians may be affiliated to one particular body or society and not another (although, of course, some may be involved in several). It is important that no individual clinician is disadvantaged because they are or are not affiliated to one body or another.

For example, there are three Colleges for Physicians and three for Surgeons in the UK. Some physicians or surgeons may be a member of more than one of the Colleges, but many are only members of a single College. It is essential that all should be in a position to make nominations.

There are occasions when, for Platinums, clinicians who are members of more than one College are nominated by both. In these circumstances the application is of course only scored once and there is certainly no advantage to the individual.

Criteria for determining accreditation

In terms of the criteria for accreditation of a nominating body we agree with a consistent process for accreditation of nominating bodies. Being a body of national standing and influence is important – although how that is exactly measured is clearly open to debate. They should certainly have a national mandate, be representative of the group they represent, and be able to show the proportion of eligible consultants in membership. They should be able to demonstrate a fair and equitable process for nominating and provide data regarding diversity and inclusion.

It may be worthwhile to note that a criterion for membership of the Academy of Medical Royal Colleges is that the organisation, whether a College or Faculty, is directly responsible for the development of training programmes/curricula that lead to the award of CCT.

All Royal Colleges and Faculties should be accredited. One single lead society for each specialty would be reasonable.

We believe it is right that nominating bodies are asked to set out their processes for ensuring equality and diversity and balanced representation of applicants. However, as stated above, whilst Colleges can and will encourage diversity of applications, at the end of the day they have to fairly manage and process those applications they receive. That may still not yet be truly proportionate.

Third Party citations

We support the proposal to limit third party citations to a maximum of two.

We believe that citations without a quality assurance process lack value. The citations should be seen and signed off by all members of the NNB or SS nominating committee.

Any further comments

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

Groups without access to local schemes

There are some non-hospital based clinical specialities that are anomalous with respect to clinical excellence awards. Public Health consultants are mostly employed by local authorities not the NHS so have no access to local awards at all which is a huge source of frustration. For Public Health doctors employed by Public Health England they have developed a work around via a separate form of recognition.

General Practice Academics were originally eligible for both local and national awards. However, since the move from PCTs to CCGs in 2013, Academic GPs lost the ability to access local CEAs as this was inadvertently not factored into the new scheme. By 2018 a new local awards scheme was



negotiated with NHS England and the BMA via hospital trusts, but this did not include academic GPs and so the inequity was cemented. As the largest clinical discipline with a relatively small but dynamic and impactful academic workforce, the loss of access to entry level (local) awards is a huge disadvantage to academic GPs. This is particularly magnified for women and BAME colleagues who are over-represented in the groups who would be eligible to apply for local awards (data available from the Society for Academic Primary Care). Whilst outside the scope of this consultation, this is a significant challenge and risks further damaging the reputation of the whole programme as being elitist and out of touch.

With the reduction in the value of national awards predicated, in part, on the opportunity to also receive local awards, this lack of access is obviously a real concern and detrimental to these academic GPs and public health consultants.

We would urge DHSC to seek a solution to this issue.

General

In conclusion we feel it is worth repeating part of the Academy's submission to the ACCEA Triennial review in 2015 which remain relevant for the current review:

The Academy supports what it sees as the core principles, which are that:

- Clinical Excellence Awards are primarily about improving patient care, outcomes and services in the NHS
- Awards are for consultants and academic GPs who achieve over and above the standards expected of them in their posts
- National awards recognise not only the high quality of local clinical practice, leadership, research and innovation and teaching but also the impact within the system of work elsewhere for the benefit of the wider NHS.

It recommends that the criteria that underpin operation of the CEA scheme are explicit about how the ACCEA's core principles and characteristics are interpreted. These criteria should be used to judge the effectiveness and fairness of operation of the scheme. It recommends that:

- The scheme should recognise the breadth of ways in which applicants can demonstrate their excellent performance against the characteristics required of successful applicants by the ACCEA. This means that:
 - The scheme should recognise that applicants' commitment to continuous improvement of the NHS can be shown in a variety of activities, work and contexts and that all of them should be given equal consideration
 - National level awards must recognise exceptional contributions to the wider NHS and reward doctors for their input through each of the domains to developing the health system in the UK as a whole, but also beyond the level of delivering care and services at local levels
- In order to achieve this objective, the national scheme should specifically:
 - Reward excellence in achievement for the wider NHS
 - Incentivise involvement in continued activities in all of the domains that contribute to improving the wider NHS
 - Support retention of national and international expertise within the UK's health services
 - Acknowledge that work for the wider NHS in the capacity of an officer or a member of a medical Royal College and other professional organisations is significant to demonstrating the characteristics of excellence and certainly should not be excluded from consideration for an award."