ACCEA

ADVISORY COMMITTEE on
CLINICAL EXCELLENCE AWARDS

2019 ACCEA Annual Report

(covering the 2018 Awards Round)

Contents

Foreword

We are pleased to present the fifteenth Annual Report from the Advisory Committee on Clinical Excellence Awards (ACCEA). We remain firmly convinced of the importance of Clinical Excellence Awards (CEAs) in recognising NHS consultants' and academic GPs' additional contributions to patient care, especially where this has national or international impact and enhances the reputation of the NHS.

In 2018, new local CEA arrangements were implemented. Although these are outside our remit, we recognise their impact on national awards and the importance of both schemes operating seamlessly. We welcome the new process whereby most national award holders who fail to renew can now revert to a local award.

In 2018, we met each sub-committee, building on strong relationships, to ensure a shared understanding of our roles in the scheme's governance and its effectiveness. We are grateful to our sub-committees, their Chairs and Medical Vice-Chairs (MVCs), all of whom ensure scoring is conducted to a consistent standard to underpin the scheme's robustness.

Our scrutiny of applications highlighted areas for discussion. In most cases, we resolved outstanding questions during the sub-committee meetings. Applications where further review was required, or where scores were tied at the cut-off point, were referred to the National Reserve committee, constituted from sub-committee Chairs and MVCs. Their scoring provides further assurance that the highest quality applicants receive awards.

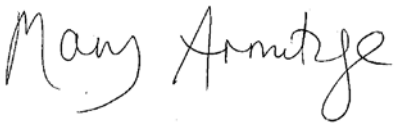
In 2018, we made changes to augment the appeals process. As in previous years, we assured applicants' right to appeal against a decision not to award or renew a CEA and with our Secretariat reviewed the processes to ensure no governance failures had occurred. This year, we strengthened the process with chairs and MVCs from regions not involved in scoring, reviewing our preliminary determinations. This provided additional assurance and insight while safeguarding applicants' rights and will be continued in 2019.

Improving diversity of applicants and sub-committees to better reflect the ethnicity and gender make-up of the eligible clinician population in national CEAs was discussed at all sub committee meetings. Many sub committees have improved their diversity through recruitment. While this is welcome, we recognise we have an ongoing duty to advance equality of opportunity so this work will continue.

We continue to work with National Nominating Bodies, including Medical Royal Colleges and Specialist Societies, sharing data and seeking their input and advice. This allows us to address issues raised, particularly where these concern equity or process governance. We are grateful to these groups and employers for their ongoing support including providing citations and applicant rankings, helping us make recommendations to Ministers.

We remain indebted to our Secretariat who manage much of ACCEA's work. They remain pivotal to the scheme's operation and its success. During 2019, with our Secretariat, we plan to continue informal consultation with relevant stakeholders on potential reform of the scheme.

Stuart Dollow
Chair



Mary Armitage
Medical Director

Part 1: About ACCEA

1.1 Our role and purpose

ACCEA is the independent advisory non-departmental public body responsible for the operation of the national CEA scheme in England and Wales. It advises Department of Health and Social Care (DHSC) Ministers and the Welsh Government on the granting of new awards.

CEAs recognise and reward consultant doctors, dentists and academic General Practitioners who provide clear evidence of clinical excellence, demonstrating achievements that are significantly over and above what they would normally be expected to deliver in their roles. These achievements are in the areas of: developing and delivering high quality services, leadership, research, innovation, teaching and training – important activities for ongoing improvement in the efficiency and effectiveness of the NHS.

We:

- Ensure that the criteria against which candidates are assessed reflect achievement over and above what would be expected within the role of a senior clinician;
- Oversee the process by which all applications are assessed and scored, ensuring consistency in approach, and training, of our regional sub-committees (for bronze, silver and gold awards) and the platinum sub-committee (for platinum awards);
- Recommend consultants for new awards (reflecting the number of new awards allocated by Ministers) and for continuation of their awards, based upon the outcome of the scoring process and taking account of advice given by the Chair, Medical Director and regional sub-committees;
- Review any changes in consultants' circumstances during the tenure of their awards that may affect their eligibility to hold an award, amending duration, pro-rata payment terms or renewal dates as appropriate;
- Oversee and monitor a system that enables appeals against the process, and any concerns and complaints to be considered; and
- Consider issues encountered and feedback received to review and adapt the administration of the scheme, making recommendations for its further development and reform.

1.2 Our governance and personnel

ACCEA is led by a Chair and a Medical Director, who are appointed by the Secretary of State for Health and Social Care. Together, they are responsible for:

- Ensuring ACCEA operates to high standards and reflects public sector values;
- Ensuring it is fair and robust in its assessment of applications;
- Ensuring it operates effectively, efficiently and transparently; and
- Advising on, and preparing for the development of, a new CEA scheme.

Chair of ACCEA – Dr Stuart Dollow

Stuart is a General Medical Council-registered physician who trained in General Medicine and General Practice. He has held senior leadership roles at Roche, GlaxoSmithKline, Norgine, Takeda and UCB. He is currently also:

- Board trustee of the Faculty of Pharmaceutical Medicine;
- Professional member of the board of the Human Tissue Authority; and
- Founder of Vermilion Life Sciences Ltd.

As Chair of ACCEA, Stuart reports to the Director-General for Acute Care and Workforce at DHSC.

His responsibilities include providing leadership to ACCEA and ensuring the effective functioning of the national CEA scheme.

ACCEA Medical Director – Dr Mary Armitage CBE

Mary is a former consultant physician and endocrinologist, who was Medical Director at Royal Bournemouth Hospital. Previously, clinical vice president of the Royal College of Physicians, Mary has been a platinum award holder and Medical Vice-Chair of ACCEA's South West regional sub-committee.

Her responsibilities include advising on the medical and professional aspects of the scheme, ensuring it reflects and rewards current best medical practice.

ACCEA Main Committee

Our decision-making body is our Main Committee. It meets to discuss and agree changes to ACCEA policy and procedure and to agree the final recommendations to Ministers for new and renewed awards. A list of members is available here.

ACCEA Secretariat

The Chair and Medical Director are supported by a secretariat of civil servants employed by DHSC. In 2018, the Secretariat was staffed by 3.5 substantive full-time equivalents (4 staff). You can contact ACCEA by e-mailing accea@dhsc.gov.uk.

1.3 Our scoring sub-committees

The ACCEA scoring process (see our Assessors' Guide) relies on the involvement of fifteen sub-committees of volunteer scorers. The sub-committees are:

- Cheshire and the Mersey
- East Midlands
- East of England
- London Northeast
- London Northwest
- London South
- Northeast
- Northwest
- Southeast
- Southwest
- South
- West Midlands
- Yorkshire and the Humber
- Arm's Length Body*
- Wales

* We have renamed the DHSC Sub-Committee to reflect its function better

We aim for each sub-committee to have 24 members recruited from within the region:

- 11 Professional members, who practise in a range of clinical specialties, including public health and academic medicine.
- 6 Employer members, who are drawn from senior management in NHS Trusts and other NHS organisations.
- 5 Lay members, who come from a wide range of backgrounds such as patient representation, Human Resources, higher education, business, law and Non-Executive Directors of NHS Trusts and may be retired consultants.
- 1 Medical Vice-Chair (MVC), who is normally a former Professional member holding, or previously having held, a Gold or Platinum award.
- 1 Chair, who is usually a former Lay member.

We are grateful to our scorers, without whom the scheme would not be able to operate. Drawing from their professional experience, they ensure that the right judgement is brought to the assessment of CEA applications. It is their scores that determine the allocation of new awards and the success of renewal applications.

In addition, MVCs and Chairs are responsible for the good governance of their sub-committees. They also score platinum applications (which are too low volume to be assessed regionally) and National Reserve applications (applications to be re-scored where a concern has been raised by sub-committee members, the Medical Director or Chair of ACCEA following the scoring process, or where there was a tie in scores for the lowest scoring new award allocated to a sub-committee at that level).

We look to refresh our sub-committee membership yearly, replacing those members stepping down or who have served their terms. Our 2018 sub-committee membership list is available here.

Scorers' training

Each year, ACCEA runs training workshops for newly recruited sub-committee members. These sessions, led by the Medical Director, include a detailed review of the scheme and practice scoring exercises. We recruited 53 new members for the 2018 round. 24 of them (and an existing member) attended the 2018 training. For those unable to attend in person, online training is available.

Our aim each year is to ensure that all new members have the opportunity to attend training before their first round of scoring. We recognise, however, that it is unreasonable to expect all new members to attend a single training session – especially as our professional members have busy clinical workloads – and we have opened these sessions up to members who have previously been unable to attend or who desire refresher training.

During 2018, we continued to improve information to support sub-committee members. Use of our internet-accessible shared workspace increased over the year and we have ensured all scorers have an account.

The training slide pack, detailed information regarding the scheme and all the guidance documents are available to all members via that workspace and we review the content regularly.

Diversity of sub-committees

Although analysis of applicant success rates (as described in the diversity analysis section) indicate that our sub-committees are not biased, we recognise the importance of ensuring they reflect the consultant community. We, therefore, regularly examine and report back to sub-committees on the gender and ethnicity of their members.

Gender

NHS Digital equality and diversity statistics at 31 March 2018 (when our 2018 competition was open) show that 36.2% of the consultant population in England was female. For each regional sub-committee to be representative, with their target membership of 24, would require nine female members.

Table 1 shows that of the fifteen sub-committees, seven have eight-or-more female members – three more than in 2017. Only two sub-committees: East of England and Southeast, now have less than 25% female representation; an improvement from 2017. Overall, the proportion of female sub-committee members has increased 4.8% since last year and we continue to work with Chairs and MVCs to increase and improve this gender representation.

Whilst only one MVC and one Chair are women, we expect these numbers to increase over time as the pool of candidates within the committees grows.

Table 1 – Sub-committee membership by gender

	Male	Female	Total	%Female
Arm's Length Body*	10	9	19	47.4%
Cheshire and the Mersey	16	7	23	30.4%
East Midlands	14	7	21	33.3%
East of England	19	4	23	17.4%
London Northeast	14	8	22	36.4%
London Northwest	14	10	24	41.7%
London South	13	10	23	43.5%
Northeast	14	8	22	36.4%
Northwest	17	9	26	34.6%
South	14	7	21	33.3%
Southeast	16	5	21	23.8%
Southwest	18	6	24	25.0%
West Midlands	14	8	22	36.4%
Yorkshire and the Humber	16	6	22	27.3%
Wales	17	6	23	26.1%
Total	226	110	336	32.7%

Medical Vice-Chairs	13	1	14	7.1%
Chairs	13	1	14	7.1%

* This sub-committee does not have a Chair or Medical Vice-Chair

Ethnicity

According to NHS Digital equality and diversity statistics, to mirror the overall consultant population, our sub-committees would, on average, be 57.9% white and 36.3% non-white (the ethnicity of 5.8% of the consultant population is unknown or unstated). In a committee of twenty-four, fourteen would be white and nine from Black, Asian or Minority Ethnic backgrounds (BAME), with one more member of any ethnicity (representing the 'not-stated' or 'unknown' ethnicities in the data).

As reported in 2017, we do not formally collect data on the ethnicity of our sub-committee members. However, we do have some partial data from our membership survey. Table 2 shows we have more work to do in this area, with six of the fifteen committees having less than half the expected BAME representation and only two bettering 30%.

Table 2 – Sub-committee membership by ethnicity

	White	BAME	Total	%BAME
Arm's Length Body*	16	3	19	15.8%
Cheshire and the Mersey	18	5	23	21.7%
East Midlands	16	5	21	23.8%
East of England	22	1	23	4.4%
London Northeast	17	5	22	22.7%
London Northwest	23	1	24	4.2%
London South	20	3	23	13.0%
Northeast	17	5	22	22.7%
Northwest	20	6	26	23.1%
South	17	4	21	19.1%
Southeast	17	4	21	19.1%
Southwest	21	3	24	12.5%
West Midlands	11	11	22	50.0%
Yorkshire and the Humber	15	7	22	31.8%
Wales	19	4	23	17.4%
Total	269	67	336	19.9%

Medical Vice-Chairs	12	2	14	14.3%
Chairs	13	1	14	7.1%

* This sub-committee does not have a Chair or Medical Vice-Chair

With the sub-committee Chairs and MVCs, we continue to encourage female and BAME consultants, employer and lay members to join the sub-committees. We invite and continue to work with the Medical Royal Colleges, Specialist Societies and NHS employers to help us to achieve this aim. Improving the diversity of the sub-committees will subsequently increase the diversity of their Chairs and MVCs as the pool of candidates broadens. We will continue to report back diversity data to our sub-committees and actively set expectations of diversity proportions in their membership.

1.4 2018 operational issues and changes

ACCEA Chair Recruitment

The previous Chair of ACCEA, Mr William Worth, stood down at the end of March 2018 and following a rigorous process in line with recruitment requirements set out by the Commissioner for Public Appointments, Dr Stuart Dollow took up his post on 1 June 2018.

Main Committee decisions

Main Committee met in November 2018 to review the outcome of the sub-committees' and National Reserve Committee scoring to make final recommendations to Ministers and to review the operation and governance of the scheme. The items below were discussed and decided upon.

Ratifying Welsh awards

Before the 2018 Main Committee meeting, ACCEA asked the Welsh Government whether, for additional consistency, Wales sub-committee awards might also be ratified by ACCEA's Main Committee. The Welsh Government agreed to this change in procedure. As such, Main Committee also made recommendations to the Welsh Government for new and renewed national CEAs.

Diversity

Main Committee discussed a draft version of 2017's Annual Report and reviewed the diversity statistics presented there. It also examined sub-committee diversity as detailed in this report. The Committee noted and agreed the issues presented and the proposed actions.

Appeals

Main Committee reviewed the 19 requests to appeal following the conclusion of the 2017 awards round. As per our process, the requests were considered by the Chair, Medical Director and Secretariat who concluded that none demonstrated grounds for appeal in line with the guidance. However, we were aware of the potential criticism that there was no independent view sought or given during the appeals process.

The Chair thus proposed to Main Committee that for 2018's appeals, the Secretariat establish two-person panels of Chairs/MVCs from outside appellants' scoring sub-committees to review the available evidence and quality assure the recommended response for each appeal request. This would introduce an additional level of scrutiny and challenge to the process. If successful, this could then be incorporated into the application guidance.

The Committee agreed the recommendation and several members volunteered to sit on the panels.

Reform of the national scheme

Main Committee reviewed the status of the national scheme to reflect on changes made in early 2018 by NHS Employers and the British Medical Association to the English local awards scheme, welcoming the reversion arrangements for national award holders who fail to successfully renew their existing national award. An interim scheme is in operation from 2018 to 2020. Amongst other changes, new local awards are not pensionable and of limited duration. A new longer-term local scheme is to be put in place for 2021.

This creates an opportunity for DHSC to review the national scheme. There has not been any official communication regarding changes and Ministers will give their views in due course, however, the previous Pay Review Body on Doctors' and Dentists' Remuneration (DDRB) recommendations provide a set of principles around which a new scheme might be shaped.

Any reform of the national scheme provides an opening to review its administration. This might include:

- Changes to the domains for assessing national CEA applications;
- Improving the application process;
- Maintaining excellence during the period covered by a CEA;
- Changing the number and value of new CEAs and removing pensionability;
- Removing progression between CEA levels.

Main Committee expressed support for the DDRB recommendations and were reassured that reform of the scheme seemed a realistic prospect. This provides an opportunity to re-orientate the scheme around NHS priorities, set out in the long-term plan, and to update our narrative about how CEAs add value to the NHS in developing and implementing cutting edge patient care. In addition, the scheme can serve to reinforce the importance of strong partnerships in important areas such as life sciences and the education sector.

Information Technology

ACCEA's online application system and awards database experienced no unplanned downtime over the application window, after which changes were made to improve user experience and operational effectiveness, including:

- A modernised user interface;
- Adding text advising users how many password attempts they have before their account will be locked;
- Removing 'was your most recent national award withdrawn?', which was causing confusion; and
- Clarifying with an asterisk which data are mandatory.

Data Protection Act 2018 compliance and data security

The European Union's General Data Protection Regulation (GDPR) came into force in May 2018 as part of the Data Protection Act 2018. This legislation means individuals have greater control over how their personal data are handled. Organisations must be clear about how they use personal data. ACCEA worked towards GDPR compliance throughout 2018.

We have a privacy notice describing what information we collect, how we process it and why and for how long it may be stored, and a permissions page requiring users' consent to our privacy policy. You will find the privacy notice and permissions page on our website.

We have also:

- Deleted records we did not need to hold and prevented their re-accumulation;
- Moved to a more modern and secure server and operating system; and
- Improved data encryption and database access monitoring.

1.5 2018 organisational finances

Chair, Medical Director and Staff

During 2018/19, ACCEA employed staff at rates within the following ranges. Please note that not all DHSC staff are full time. Where applicable, Civil Service grades are included in brackets:

- Chair of ACCEA £52,540 for 2 days a week*
- Medical Director £52,540 for 2 days a week
- 1x Team Leader (Grade 7, DHSC) £47,610 to £58,476
- 1x Service Manager (SEO, DHSC) £35,393 to £42,269
- 2x Service Officer (EO, DHSC) £22,532 to £26,775

* The Chair's post was vacant between 1 April and 31 May 2018

These figures exclude pension costs, National Insurance contributions and performance-related pay.

The Chair and Medical Director are entitled to claim for travel and expenses. In 2018/19, this totalled £3,068.

It is not possible to split out the Secretariat's travel, expenses accommodation or corporate IT costs, which are incorporated into DHSC's annual report and accounts.

Sub-committees

Our lay members are eligible to claim an allowance for their scoring and for travel and expenses. Over 2018/19, 86 members were eligible, and they claimed a total of £89,697.

IT

<u>Sapient</u>
In 2018/19, Sapient won a further G-Cloud (government procurement framework) contract to develop our IT system up to the end of 2018. This contract was worth £322,079.

<u>Atos</u>
Atos hosted ACCEA's application process until August 2018 as part of its IT Services contract with DHSC. It is not possible to separate out Atos' ACCEA related costs, which are incorporated into DHSC's annual report and accounts.

<u>Navisite</u>
Navisite was awarded a G-Cloud contract to provide infrastructure services (taking over from Atos) worth £230,068 over two years. They have been further contracted from 1 January 2019 to provide application support and 251 hours of software support (in place of Sapient).

Part 2: the 2018 Awards Round

2.1 Finances of national CEAs

Funding flows

ACCEA only holds the budget for awards paid to consultants who work for NHS Blood and Transplant. Awards money for National Institute for Health and Care Excellence, Public Health England, and Health Education England consultants are included in those organisations' budgets.

Most English awards – those for consultants who work for NHS England and NHS Trusts – are funded from NHS England's budget. Universities employing academic consultants with CEAs recover costs for funding those CEAs from Trusts holding the academic consultants' honorary contracts.

Welsh awards are funded by the Welsh Government. Universities in Wales employing academic consultants recover costs for funding those CEAs from the relevant NHS organisation holding the academic consultants' honorary contract.

Award values 2018/19

Awards payment amounts depend on the number of programmed activities (PAs) an award holder undertakes. For most consultants on the current contract, we consider ten or more PAs to be full time, but for academic clinicians, five or more NHS PAs in addition to their academic contract, attract the full award value. Awards are paid annually for five years.

During 2018, the Government rejected the DDRB recommendation to uplift Consultant salaries. Consequently, our award values remained at their 2017/18 rates.

As national awards are pensionable, we also ensure employer on-costs are reimbursed. In the first half of the financial year, we agreed with NHS England to increase on-cost remuneration rates to reflect changes in National Insurance and pension scheme contribution rates. For non-academics, these increased from 27.8% to 28.18% and for academics from 29.0% to 31.8%. The values of full awards and on-costs for clinical consultants and academic consultants on the current consultant contract are shown in Tables 3 and 4 respectively.

Table 3 – CEA values in 2018/19 with clinical consultant on-costs

Full time consultants (10+PAs)	Award value	On-costs at 28.18%	Total
Bronze	£36,192	£10,199	£46,391
Silver	£47,582	£13,409	£60,991
Gold	£59,477	£16,761	£76,238
Platinum	£77,320	£21,789	£99,109

Table 4 – CEA values in 2018/19 with academic consultant on-costs

Full time academic consultants (5+PAS)	Award value	On-costs at 31.8%	Total
Bronze	£36,192	£11,509	£47,701
Silver	£47,582	£15,131	£62,713
Gold	£59,477	£18,914	£78,391
Platinum	£77,320	£24,588	£101,908

Tables 5 and 6 detail the total value and breakdown of the National Roll of CEA holders as of August 2019 and represents the position at the end of the 2018 award round. The total value of CEAs in England and Wales was just over £135m in 2018/19.

As of August 2018, there were 2,175 Consultants in receipt of CEAs, most at bronze or silver level. As a result of the 2018 award round, a further 317 new awards were granted, with payment backdated to April 2018.

Table 5 – Total value of CEAs in 2018/19

Awards Round	Financial Year	Wales	England	Total
2018	**2018/19**	£6,249,260	£129,587,301	£135,836,561

Table 6 – Awards in payment (England and Wales) August 2018

Total number of CEAs			
2,175 awards			
Of which			
Bronze awards	**Silver awards**	**Gold awards**	**Platinum awards**
1,103	732	245	95

2.2 2018 renewal applications

During the 2018 awards round, we received 454 applications for the renewal of national CEAs. Table 7 shows the outcome of those applications. 264 (58%) of applicants succeeded in renewing their awards, 233 (51%) of whom renewed at the same level and 31 (7%) at a lower level; not scoring enough to renew at their existing level, but at a sufficient standard to maintain a national award. 96 (21%) secured a higher award so are included in the 317 new awards granted from the 2018 awards round. There were 94 applicants (21%) unsuccessful in renewing their national award, most at bronze, who were covered by the new interim local reversion arrangements announced during the 2018 award round.

Table 7 – Renewal outcomes 2018

	No	% Total
Successful renewals	264	58%
(Of which renewed at a lower level)	(31)	(7%)
Applicants renewing and successful at higher level	96	21%
Unsuccessful renewals	94	21%
Total Renewal Applications	**454**	**100%**

2 of the 233 applicants who successfully renewed their awards at the same level had their existing award extended at the same level for one year, as opposed to a normal five-year renewal. These applicants were Academic GPs who had not scored at a sufficient level to retain a national award, but as it was not clear at that time whether the reversion scheme would apply to Academic GPs, it was agreed by Main Committee to extend their existing award for one year to allow them to reapply in 2019 when clarity on their applicability was expected.

Table 8 shows that of the 31 applicants who renewed at a lower level, all-but 4-dropped one level, with just under half transferring from silver to bronze.

Table 8 – Renewals at lower levels 2018

Moved from Silver to Bronze	15
Moved from Gold/A to Silver	4
Moved from Gold/A to Bronze	2
Moved from Platinum/A+ to Gold	8
Moved from Platinum/A+ to Silver	1
Moved from Platinum/A+ to Bronze	1
Total	**31**

Table 9 – Unsuccessful renewals by level 2018

	Unsuccessful	Applications	% Unsuccessful
Platinum/A Plus	1	23	4%
Gold/A	1	33	3%
Silver	20	136	15%
Bronze/B	72	262	27%
Total/Overall	**94**	**454**	**21%**

Table 9 shows the breakdown of the unsuccessful national renewals. As there are progressively fewer awards in payment at the higher award levels, a greater number of unsuccessful bronze renewal applicants can, to an extent, be expected. They were however proportionately less likely to secure renewal, with 27% unsuccessful compared to those renewing silver (15%), gold (3%) or platinum (4%).

The success of applications to renew awards is dependent on the scores of applications for new awards at the same level scored by the same sub-committee, maintaining our principles of regional equity of opportunity. As such, the quality and volume of applications for those new awards in the current and last 3 years (as we also apply a 3-year rolling average score) are factors in renewal success. This is unrelated to the numbers of applicants for new awards in each region as renewal awards are not limited in numbers in the same way as new awards. Cross-regional comparisons are shown in Table 10, but care should be taken as each sub-committee scores independently.

Table 10 – Unsuccessful renewals by sub-committee 2018

Region	Unsuccessful	Renewal Applications	% Unsuccessful
ACCEA Arm's Length Body Committee	2	8	25%
Cheshire & Mersey Sub Committee	1	13	8%
East Midlands Sub Committee	10	29	34%
East of England Sub Committee	11	35	31%
London North East Sub Committee	11	53	21%
London North West Sub Committee	5	33	15%
London South Sub Committee	9	38	24%
North East Sub Committee	7	29	24%
North West Sub Committee	1	29	3%
South East Sub Committee	2	14	14%
South Sub Committee	1	43	2%
South West Sub Committee	7	42	17%
Wales	10	23	43%
West Midlands Sub Committee	7	28	25%
Yorkshire & Humber Sub Committee	10	37	27%
Total	**94**	**454**	**21%**

2.3 Analysis of 2018 new awards

Summary Statistics

Table 11 shows:

- There were 1,032 applications to the National CEA scheme in the 2018 award round which included those applying for an award at a different level and those applying for the first time.
- Just over 50% of applications (539) were for bronze awards.
- 317 new awards were granted in 2018 with a success rate for applicants of 31%

Table 11 – Applications and Awards by Level for 2018 Round

Level	Applications	Awards	Success Rate
Bronze	539	162	30%
Silver	331	105	32%
Gold	133	42	32%
Platinum	29	8	28%
Total	**1,032**	**317**	**31%**

Table 12 shows the amount of time someone is a consultant before obtaining a Bronze award, in most cases, it takes at least 10 years.

Table 12 – Time Spent as Consultant prior to obtaining Bronze Award

Time as Consultant	Awards	Awards %
1 - 5 Years	6	4%
6 - 10 Years	38	23%
11 - 15 Years	69	43%
16 - 20 Years	33	20%
21 Years +	16	10%

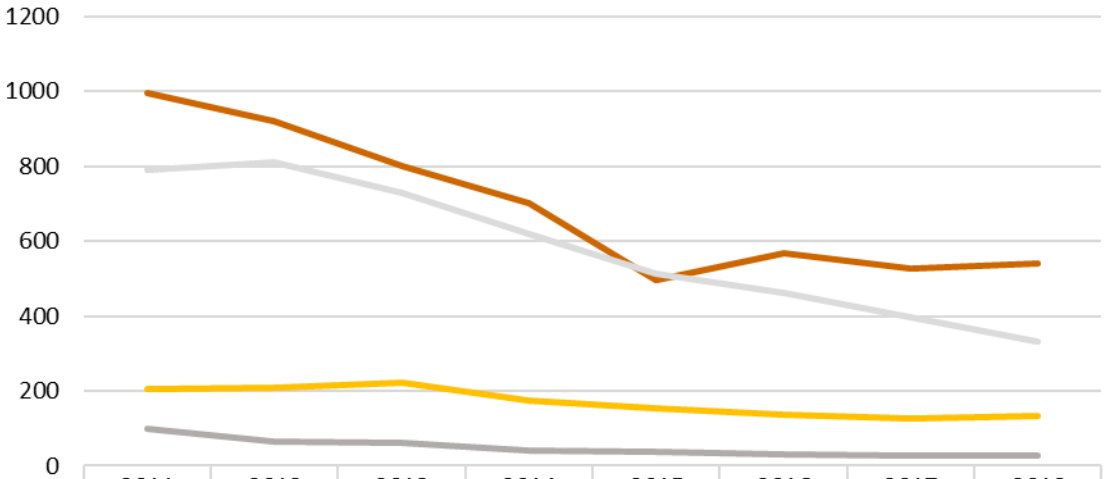
Application numbers over time

Application numbers for new national CEAs continue to fall with 6% fewer applicants in 2018 compared to 2017, however, the number of applicants has stabilised since 2015. Over the longer-term, factors including the decision in 2010 to halve the number of new awards from 600 to 300 may account for some of the reduction in applicants.

With the reduction in the number of new awards, the pool of award-holders who can apply for a new higher-level award is also shrinking. So, numbers of applications have fallen across

all award levels since 2011. Figures for the last four rounds suggest that the number of applicants at Gold, Platinum and Bronze have stabilised however the number of applicants at Silver continues to decrease, falling by almost 50% since 2014 as highlighted in Chart 1.

Chart 1 – New applications by level and year from 2011 to 2018



	2011	2012	2013	2014	2015	2016	2017	2018
Bronze	996	919	802	702	497	569	526	539
Silver	789	811	730	620	512	463	396	331
Gold	206	208	224	174	153	137	127	133
Platinum	100	64	60	42	36	31	29	29

Diversity

At ACCEA, we believe in taking all necessary steps to achieve equality and diversity, having regard to the need to: eliminate discrimination; advance equality; and foster good relations between groups. To ensure our process remains fair and unbiased (in accordance with these duties), we look at statistics, including application and success rates for different groups.

Figures are based on data extracted from the ACCEA database which, in turn, uses information provided by applicants. That information is not centrally validated. There may, therefore, be minor discrepancies between tables based on data issues (e.g. erroneous dates of birth) or some applications being withdrawn at different stages of the application process.

<u>Age</u>

Newly appointed consultants need time to build up the evidence required to achieve a bronze award. Applicants for higher awards may not re-use evidence from previous successful applications. In addition, the structure of CEAs is such that consultants must progress from a bronze award (or local level 9) through silver, gold to a platinum award.

This means that we would expect the average age of award holders to increase with the award level as indicated in Table 13.

Table 13 – Average age of successful 2018 applicants for a new award at August 2019 by award level

Level	Mean age (years)
Bronze	50.4
Silver	53.9
Gold	55.9
Platinum	59.7

Table 14 – 2018 applications and success rate for new awards by age group

		Bronze	Silver	Gold	Platinum	Total
< 35*	Applications	4	-	1	2	**7**
	Awards	0	-	0	0	**0**
	Success rate	0	-	0	0	**0%**
36-40	Applications	19	-	-	-	**19**
	Awards	3	-	-	-	**3**
	Success rate	16%	-	-	-	**16%**
41-45	Applications	93	2	-	-	**95**
	Awards	32	1	-	-	**33**
	Success rate	35%	50%	-	-	**35%**
46-50	Applications	149	48	7	-	**204**
	Awards	50	26	3	-	**79**
	Success rate	34%	54%	43%	-	**39%**
51-55	Applications	141	124	37	3	**305**
	Awards	46	37	13	0	**96**
	Success rate	33%	30%	35%	0%	**31%**
56-60	Applications	110	128	72	12	**322**
	Awards	29	37	24	6	**96**
	Success rate	26%	29%	33%	50%	**30%**
61-65	Applications	20	28	15	9	**72**
	Awards	2	4	2	1	**9**
	Success rate	10	14%	13%	11%	**13%**
66-70	Applications	3	1	1	3	**8**
	Awards	0	0	0	1	**1**
	Success rate	0%	0%	0%	33%	**13%**

* Given the length of the training pathway for Consultants, and the time taken to apply for different award levels, there may well be data errors where individuals have not recorded an accurate date of birth.

Table 14 shows there is a pattern when it comes to age and applicant success with the highest success rates for applicants between the ages of 46 and 50.

Gender

In the past year, there has been an increased focus on the gender pay gap, the difference in average earnings of Male and Female employees, in the NHS and wider UK economy. In

medicine, coverage has commented that CEAs magnify the effect of the gender pay gap with most awards going to men.

Examining the numbers of new awards made to both genders in 2018, there is a difference: with 247 awards to men and 70 to women. This however is not the full picture as this does not consider the composition of the workforce nor those who are applying for awards.

As shown in our recent Annual Reports, when female consultants do apply, their percentage success rate is generally comparable to their male colleagues. Table 15 shows that in 2018, 31.3% of male applicants received new awards, compared to 30.2% of female applicants – This was the highest success rate for female applicants since 2013.

Table 15 – 2018 applications and success rate by gender

	Applicants n	Applicants %	Awards n	Awards %	Success rate
Female	232	22.7%	70	22.1%	30.2%
Male	790	77.3%	247	77.9%	31.3%
Total	**1022***	**100.0%**	**317**	**100.0%**	**31.0%**

* The number of applications does not equal the total number of applications in Table 11 as ten applicants did not have gender information recorded.

The closeness of the success rates of male and female applicants over the last six years (as shown in Table 16), reassure us that our scoring mechanism and the sub-committees carrying out the scoring are not biased towards either gender. To further protect against bias, we continue to focus on recruiting more women onto ACCEA's regional sub-committees (see the Diversity of sub-committees section).

The key disparity between the genders however is that women consultants are greatly under-represented as a proportion of applicants. In 2018 only 22.7% of applicants were female while 36.2% of the consultant workforce is female (NHS Digital equality and diversity statistics, 31 March 2018). This gap was even bigger for higher award levels, 17% female applicants for silver and gold, 14% for platinum because award holders must progress from bronze (or local level 9) to silver to gold to platinum (see Table 17).

Table 16 – Success rates by gender 2013 to 2018

	2013	2014	2015	2016	2017	2018
Female	15.9%	16.5%	26.4%	25.6%	26.7%	30.2%
Male	17.8%	21.7%	26.5%	26.8%	30.2%	31.3%
Overall	17.5%	20.7%	26.5%	26.5%	29.5%	31.0%
Gap	-1.9%	-5.2%	-0.1%	-1.2%	-3.5%	-1.1%

Table 17 – 2018 Success rate by gender and award level

Level	Gender	Applications	% Apps at Level	Awards	Success Rate
Bronze	Female	149	28.0%	44	29.5%
	Male	384	72.0%	118	30.7%
Silver	Female	57	17.3%	17	29.8%
	Male	272	82.7%	88	32.4%
Gold	Female	22	16.8%	7	31.8%
	Male	109	83.2%	35	32.1%
Platinum	Female	4	13.8%	2	50.0%
	Male	25	86.2%	6	24.0%
All Levels	**Female**	**232***	**22.7%**	**70**	**30.2%**
	Male	**790***	**77.3%**	**247**	**31.3%**

* As with Table 15, the "all levels" numbers do not tally with the total number of applications in Table 11 as ten applicants did not have gender information recorded.

This is a long-standing issue and despite much formal encouragement through the Royal Colleges and the Medical Women's Federation, applications from female consultants still lag behind those of their male colleagues, particularly at the higher award levels. As we meet with our sub-committees during the 2019 round, we will seek regional perspectives on why women are less likely to apply and ask for sub committees' help in reducing this gap.

DHSC commissioned an independent report to examine how doctors – regardless of their gender – can be rewarded fairly for their work. The gender pay gap review will examine why the gap exists and is expected to identify obstacles that may prevent female doctors from progressing in their careers. It is also considering the impact on the gender pay gap of: having children, working patterns, care arrangements, access to flexible working, shared parental leave, the predominance of men in senior roles and CEAs. We will co-operate fully with the review, providing access to any relevant data as needed, and take seriously any recommendations it makes.

<u>Ethnicity</u>

For diversity and fairness monitoring purposes, applicants for national CEAs are asked to declare their ethnicity, however, our scorers do not have access to this data.

Looking at statistics on ethnicity from the 2018 round (Table 18), we can see that consultants from BAME backgrounds received 16% of the awards compared with their making up 22% of applications and being 36% of the workforce. The number of BAME applicants and award recipients was lower than in previous years. Although there is some variation by different award level, we are disappointed to see that the overall success rates are mostly lower for non-white applicants. Actual numbers could differ as 8% of applicants, and 10% of new award holders, did not declare their ethnicity.

Table 18 – 2018 applications and success rate by ethnicity and award level

Level	Ethnicity	Applications	% Apps at Level	Awards	Success Rate
Bronze	**White**	360	67%	112	31.1%
	BAME	131	24%	30	22.9%
	Not Stated	48	9%	20	41.7%
Silver	**White**	237	72%	79	33.3%
	BAME	71	21%	17	23.9%
	Not Stated	23	7%	9	39.1%
Gold	**White**	108	81%	36	33.3%
	BAME	19	14%	4	21.1%
	Not Stated	6	5%	2	33.3%
Platinum	**White**	26	90%	6	23.1%
	BAME	2	7%	1	50.0%
	Not Stated	1	3%	1	100.0%
Overall	**White**	**731**	**71%**	**233**	**31.8%**
	BAME	**223**	**22%**	**52**	**23.3%**
	Not Stated	**78**	**8%**	**32**	**41.0%**

Table 19 compares the success rates for different ethnic groups since 2013. We see that 2018 saw the lowest success rate for BAME applicants since 2014 (23%). While we believe scoring is fair and unbiased and ethnicity is not a factor, we will continue to analyse and review BAME clinicians' success rates to ensure this issue does not worsen and develop into a more unwelcome trend.

Table 19 – BAME Applications and Success Rates (2013 – 2018)

BAME Ethnicity	2013	2014	2015	2016	2017	2018
Applications	302	280	221	234	237	223
Awards	50	39	66	61	61	52
BAME Success	16.6%	13.9%	29.9%	26.1%	25.7%	23.3%
White Success	17.9%	21.6%	25.9%	26.8%	30.2%	31.8%
Gap	**-1.4%**	**-7.7%**	**4.0%**	**-0.8%**	**-4.4%**	**-8.5%**

However, as with women consultants, BAME consultants are under-represented as a proportion of applicants when compared with the wider consultant population. NHS Digital equality and diversity statistics (31 March 2018) tell us that 36.3% of consultants were non-white (5.8% of consultants' ethnicity is unknown) whereas, as already stated, only 22% of applicants for new CEAs in 2018 were consultants from BAME backgrounds although 78 (7.6%) did not state their ethnicity.

We will continue to encourage applications from all sectors of the consultant community and seek the help of the sub-committees, the Royal Colleges and Specialist Societies as well as special interest groups such as the British Association of Physicians of Indian Origin in promoting CEAs, particularly (as discussed above) reinforcing and reporting back on improving ethnic diversity in our sub-committees as an important aspect.

Sexual orientation, gender reassignment, religion, marital status, pregnancy and disability

ACCEA does not collect data on these protected characteristics as applicants' statuses are less likely to be identifiable from their application forms. We will, however continue to take proportionate measures to ensure that our processes and technologies do not disadvantage consultants based on any of these characteristics.

Distribution by region and specialty

ACCEA ensures awards are fairly distributed across the English regions and Wales. We like to see a wide range of medical specialties, dentistry and public health represented amongst awardees.

Regional distribution

An underlying principle of the national CEA scheme is that there should be equity of opportunity of success across the regions and at each award level (including the small number of platinum applications, which are scored nationally).

In England, ACCEA distributes the 300 potential new awards authorised by Ministers in a forced distribution that results in comparable success rates across the regions and the award levels. In Wales, there is a maximum budget allocated for new awards, so actual award numbers vary depending on success at higher award levels. There are usually around 17 or 18 Welsh awards made each year.

As commented above, Table 20 shows that across England the outcome is broadly equitable, with each region achieving the planned success rate close to the overall rate of 30%, acknowledging that in small regions or at the higher levels where there are fewer applications, the success rates can vary more widely. Additionally, the rescoring of a few applications in the National Reserve quality assurance and tie-break process may result in some regions gaining or losing a small number of awards (as is the case for bronze awards in the Southeast and silver awards in the East of England respectively).

Distribution across specialties

ACCEA monitors the distribution of new awards and application numbers across the specialties. Should specialties be under-represented in terms of number of applications or success rates, we seek the help of the relevant professional body or Royal College to explore this and encourage more applications. Following each application round, we hold a detailed feedback meeting with the National Nominating Bodies, to discuss ways in which we can collectively help those specialties that are less successful.

Table 21 and Chart 2 show that, as expected, the larger specialties tend to have a higher number of applicants. For example, General Medicine and Surgery have the largest number of applicants and the largest workforce. On the other hand, Anaesthetics is under-represented accounting for 15% of the workforce but only 6% of applications.

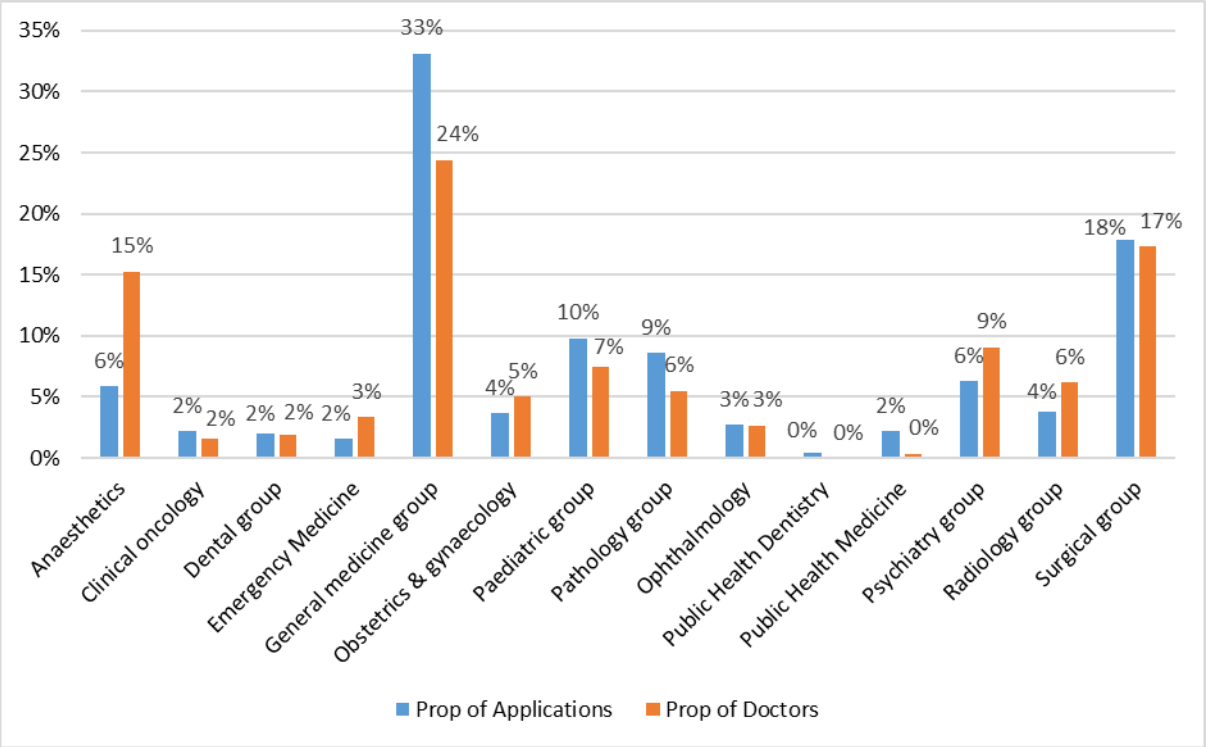
Table 20 – 2018 applications and success rate by ACCEA sub-committee

	Bronze			Silver			Gold			Platinum			All		
Region	**Apps**	**Awards**	**Success Rate**	**Apps**	**Awards**	**Success Rate**	**Apps**	**Awards**	**Success Rate**	**Apps**	**Awards**	**Success Rate**	**Apps**	**Awards**	**Success Rate**
ACCEA ALB	15	3	20%	10	3	30%	1	1	100%	-	-		**26**	**7**	**27%**
Platinum Committee	-	-	-	-	-	-	-	-	-	29	8	28%	**29**	**1**	**8%**
Cheshire & Mersey	21	8	38%	14	4	29%	5	1	20%	-	-	-	**40**	**13**	**32%**
East Midlands	23	6	26%	22	4	18%	12	4	33%	-	-	-	**57**	**15**	**25%**
East of England	43	15	35%	18	6	33%	4	2	50%	-	-	-	**65**	**23**	**35%**
London North East	54	19	35%	52	16	31%	23	8	35%	-	-	-	**129**	**43**	**33%**
London North West	33	11	33%	16	5	31%	9	3	33%	-	-	-	**58**	**21**	**34%**
London South	41	12	29%	22	9	41%	9	3	33%	-	-	-	**72**	**25**	**34%**
North East	20	6	30%	22	7	32%	4	1	25%	-	-	-	**46**	**15**	**31%**
North West	53	17	32%	27	9	33%	14	4	29%	-	-	-	**94**	**30**	**32%**
South East	25	8	32%	11	2	18%	7	2	29%	-	-	-	**43**	**12**	**28%**
South	42	13	31%	30	9	30%	12	4	33%	-	-	-	**84**	**26**	**31%**
South West	42	11	26%	27	8	30%	10	3	30%	-	-	-	**79**	**23**	**28%**
West Midlands	26	8	31%	16	6	38%	8	3	38%	-	-	-	**50**	**18**	**35%**
Yorkshire & Humber	49	15	31%	28	11	39%	8	2	25%	-	-	-	**85**	**28**	**33%**
Wales	52	10	19%	16	6	38%	7	1	14%	-	-	-	**75**	**17**	**23%**
Total England	**487**	**152**	**31%**	**315**	**99**	**31%**	**126**	**41**	**33%**	**29**	**8**	**28%**	**957**	**300**	**31%**
Total England and Wales	**539**	**162**	**30%**	**331**	**105**	**32%**	**133**	**42**	**32%**	**29**	**8**	**28%**	**1032**	**317**	**31%**

Table 21 – 2018 applications and success rate by specialty

Specialty	Bronze			Silver			Gold			Platinum			Total		
	Apps	Awards	Success Rate	Apps	Awards	Success Rate	Apps	Awards	Success Rate	Apps	Awards	Success Rate	Apps	Awards	Success Rate
Academic GP	6	2	33%	4	1	25%	2	0	0%	0	0	-	**12**	**3**	**25%**
Anaesthetics	25	6	24%	24	5	21%	10	1	10%	1	0	0%	**60**	**12**	**20%**
Clinical Oncology	16	8	50%	3	1	33%	3	1	33%	-	-	-	**22**	**10**	**45%**
Dental	12	2	17%	7	1	14%	1	0	0%	-	-	-	**20**	**3**	**15%**
Emergency Medicine	12	3	25%	2	1	50%	2	0	0%	-	-	-	**16**	**4**	**25%**
Medicine	176	60	34%	102	38	37%	51	18	35%	9	2	22%	**338**	**118**	**35%**
Obs and Gynaecology	19	5	26%	13	3	23%	2	0	0%	3	2	67%	**37**	**10**	**27%**
Ophthalmology	9	2	22%	10	3	30%	8	3	38%	1	0	0%	**28**	**8**	**29%**
Paediatrics	54	20	37%	30	10	33%	11	5	45%	5	2	40%	**100**	**37**	**37%**
Pathology	49	16	33%	28	7	25%	9	2	22%	2	2	100%	**88**	**27**	**31%**
Psychiatry	35	8	23%	20	7	35%	8	3	38%	1	0	0%	**64**	**18**	**28%**
Public Health Dentistry	2	0	0%	2	0	0%	-	-	-		-	-	**4**	**0**	**0%**
Public Health Medicine	11	2	18%	8	1	13%	1	1	100%	2	0	0%	**22**	**4**	**18%**
Radiology	19	4	21%	18	5	28%	2	1	50%	-	-	-	**39**	**10**	**26%**
Surgery	93	23	25%	60	22	37%	23	7	30%	5	0	0%	**181**	**52**	**29%**
Total	**539**	**162**	**30%**	**331**	**105**	**32%**	**133**	**42**	**32%**	**29**	**8**	**28%**	**1032**	**317**	**31%**

Chart 2 - Proportion, by specialty, of applications for new awards versus E+W population 2018



It should be noted that the proportion of consultants in each specialty does not directly represent the proportion of eligible consultants. Consultants are only eligible after a minimum of one year of employment in role. We do not hold data at this level of detail so the graph should be read as being indicative. Nevertheless, we continue to seek the views of the Academy of Medical Royal Colleges on these results with a view to increasing applications from under-represented specialties and improving proportionate success rates.

2.4 Appeals and concerns

Once each round is concluded, consultants can appeal. In 2018, applicants had until either Friday 25 January 2019 or within four weeks of the award results being announced to appeal, whichever was the later.

As described in the Guide for Applicants, consultants cannot challenge their score or the outcome of the application process. However, if they can show that ACCEA has not followed its own procedures or that the process has been biased, they can request an appeal. If the grounds for appeal are upheld, ACCEA convenes a panel to review the processes and concerns.

The numbers of appeal requests continue to fall. Following the 2018 competition, ACCEA received 15 requests. These came from 10 of the 13 English regions and Wales. Grounds for appeal requests included:

Process issues:

- Different scores being provided for the same evidence (bronze renewal and silver new);
- Scores and success thresholds varying by year;
- Scores being lower in certain domains;
- Some regions being allocated fewer new awards than others.

Alleged sub-committee failures:

- The sub-committee not making proper allowances for part-time working and so discriminating against women;
- The sub-committee failing to consider all the materials presented (including the citations and employer statement);
- The sub-committee not appreciating the significance of the achievements presented;
- The sub-committee not coming to the same conclusion as the applicant's Royal College as to the suitability of the applicant for an award;
- Two sub-committee members being biased against a consultant who was known to them. (Determined that the two members named did not score the application);
- ACCEA procedural and sub-committee bias towards academics and the teaching centre within the region;
- ACCEA procedural and sub-committee bias towards larger specialties.

Other issues:

- Illness at the time of application;
- Trust scores (entered during sign-off of the application) disadvantaging the applicant;
- A failure in Trust job planning procedures adversely affecting application.
- A breach of confidentiality due to data disclosure.

All requests to appeal were considered by the Chair, Medical Director and Secretariat. None were considered to have sufficient grounds for appeal. This year, to reinforce the appeals process, we forwarded the appeal correspondence and our proposed responses to Chair and MVC panels from different regions from the appellant to seek their views. The panels agreed with our conclusions and no appeals progressed.

2.5 Outcome and assessment of the round

Our application window was open from 13 February to 12 April 2018 during which time the Secretariat answered over 880 telephone calls and received and responded to hundreds of e-mails. By the application window close, we had received 1,032 applications for new awards and 454 applications for renewals.

Following 6 weeks of scoring, 26 sub-committee meetings across England and Wales, involving over 325 scorers, and the National Reserve re-scoring exercise, 317 new awards, 233 successful renewals and 31 renewals at lower levels (those not having scored enough to be successful at the existing award level) had been recommended. The ACCEA Main Committee met in November to agree the final list of awards, before the English and Welsh names were submitted to the respective Ministers.

In December 2018, DHSC's Minister of State for Health, Stephen Hammond MP, agreed the recommended English awards. In Wales, the Minister for Health and Social Services, Vaughan Gething AM, agreed the Welsh awards. Shortly before Christmas, ACCEA contacted consultants and then their employers to make them aware of the outcome of their applications, successfully completing the award round to the planned timetable.

Annex: Summary of commitments made in this report

ACCEA is committed to learning from each award round and developing and implementing improvements each year. Work will continue to address the following commitments, as adapted from prior years, building on the progress we have made as outlined in this Report. We will continue to report on our progress.

Equality and diversity:

- We commit to improving our membership diversity and the robustness of our data (see Diversity of sub-committees) to allow us, with our sub-committee Chairs and Medical Vice-Chairs, to continue to report back on our expectations of diversity of their membership and to encourage female and BAME consultants to join the sub-committees. We invite the Medical Royal Colleges, Specialist Societies and NHS employers to work with us to achieve this aim. As we meet with our sub-committees during the 2019 round, we will continue to seek regional perspectives on why women are less likely to apply and ask sub committees for their help (see Diversity analysis).
- We will co-operate with the gender pay gap review, providing access to any relevant data needed, and will take seriously any recommendations it makes.
- We will continue to analyse and review the success rate of BAME applicants and re-emphasise our work to make our sub-committee membership more representative of the consultant population (see Diversity analysis).
- We will continue to encourage applications from all sectors of the consultant community and seek the help of the sub-committees, the Royal Colleges and Specialist Societies as well as special interest groups such as the British Association of Physicians of Indian Origin in promoting CEAs (see Diversity analysis).
- We will continue to take proportionate measures to ensure that our processes and technologies do not disadvantage consultants because of any sexual orientation, gender reassignment, religion, marital status, pregnancy or disability (see Diversity analysis).

Improving award spread amongst specialties:

- We will seek the views of the Academy of Medical Royal Colleges on the 2018 results with a view to increasing applications from under-represented specialties and improving proportionate success rates (see Distribution by region and specialty).

Improving our processes:

- We will continue to invite our sub-committee members to training sessions, especially focusing on those who have previously been unable to attend or who desire refresher training (see Scorers' training).

- We will continue to improve the training and other content hosted on the sub-committee workspace, ensuring those members who cannot attend face to face training can avail themselves of this resource.
- We will continue to solicit views on the operation of the scheme to both improve the way it works, as well as to identify key themes upon which to focus our planning for consultation on scheme reform from 2021. This will occur during 2019 to allow us to plan our consultation in due course. (see Main Committee decisions).

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Advisory Committee on Clinical Excellence Awards

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