ACCEA

ADVISORY COMMITTEE on
CLINICAL EXCELLENCE AWARDS

# 2018 ACCEA Annual Report

## (covering the 2017 Awards Round)

# Contents

# Foreword

We are pleased to present the fourteenth Annual Report from the Advisory Committee on Clinical Excellence Awards (ACCEA). Clinical Excellence Awards' (CEAs) are important to acknowledge the work of senior NHS consultants and academic GPs who make a substantial impact on patient care. The practice of medicine and dentistry is demanding and often requires working outside formal contracted arrangements. ACCEA recognises and rewards those clinicians who perform at the highest level, with national impact.

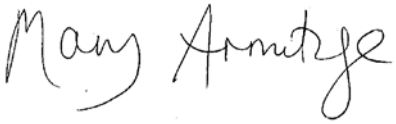
As the chief officers of ACCEA we are accountable for ensuring consistently high standards are applied to the national CEA process. An essential component of good governance is the work of ACCEA's regional sub-committees, whose dedication to high-quality scoring underpins ACCEA's recommendations to ministers. We work closely with these sub-committees to refresh their membership and train new members, while ensuring they represent the gender and ethnic diversity of the population of eligible consultants, as well as the range of specialties and workplaces. The National Nominating Bodies, such as Medical Royal Colleges and Specialist Societies, and employers are also an essential part of our governance, providing support, citations and ranking of applicants. We are most grateful for this work.

We carefully review all applications that are provisionally recommended for awards by sub-committee scoring. Applications that require clarification or additional consideration are discussed at the relevant final sub-committee meeting. Should we consider that further assessment is required, we recommend these applications are rescored by a National Reserve committee (NRES) comprising the Chairs and Medical Vice-Chairs of the regional sub-committees, providing further peer review and quality assurance. Those who rescore highly by NRES will go forward. Finally, we assure applicants' right to appeal against a decision not to renew or award a new CEA, responding fully to matters raised and acting on any learning.

Recently there has been publicity regarding the gender pay gap in the UK. We closely monitor the success rates of women and those from Black, Asian and Minority Ethnic (BAME) groups. While success rates by gender and ethnicity are broadly in line with the overall success rate, women and BAME are underrepresented as applicants and sub-committee members. Equality and diversity remain an important focus and priority for ACCEA and we will work to address this gap in representation.

With our Secretariat, Main Committee and sub-committee colleagues we continually review the operation of the scheme, drawing on previous years' experience to ensure the scheme operates as efficiently and effectively as possible. The dedication of our small Secretariat team underpins this, and we are most grateful for their hard work. We also extend our thanks to our outgoing Chair, William Worth, who served as ACCEA Chair for four years, and previously as Chair of our North West sub-committee. Bill worked tirelessly to improve the governance of the scheme and was greatly valued by our stakeholders for his emphasis on transparency and good communications.

**Stuart Dollow**
Chair



**Mary Armitage**
Medical Director

# Part 1: About ACCEA

## 1.1 Our role and purpose

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

Clinical Excellence Awards (CEAs) recognise and reward consultant doctors and 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, and teaching and training –important activities for ongoing improvements 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 the 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 (based upon 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;
- 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 as appropriate.

## 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 that 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 the Department of Health and Social Care.

His responsibilities are: to provide leadership to ACCEA and to be personally responsible for the effective functioning of the national CEA scheme.

During the 2017 Awards Round, ACCEA was led by Mr William Worth, who stood down on 31 March 2018.

**ACCEA Medical Director – Dr Mary Armitage CBE**

Mary is a former consultant physician and endocrinologist, who was Medical Director at Royal Bournemouth Hospital. She was previously 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 small secretariat of civil servants, who sit within, and are employed by, the Department of Health and Social Care. In 2017, the Secretariat was staffed by 3.5 substantive full-time equivalents (4 staff), with 1 additional temporary staff member from May onwards.

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
- Department of Health
- Wales

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 most 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 last 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 2017 sub-committee membership list is available here.

**Scorers' training**

ACCEA runs an annual training workshop 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 43 new members for the 2017 round and 28 members attended the 2017 training.

Our aim is to ensure that each year most 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 commit to opening these sessions up to members who have previously been unable to attend or who desire refresher training.

In addition, during 2017 we began a review of the documentation we provide to support sub-committee members and have made this more easily available via an internet-accessible shared workspace. The training slide pack, detailed information regarding the scheme and all the guidance documents are now available to all members via that workspace. We will also look at what additional content could be hosted on the workspace, such as providing reference information on data handling and on avoiding unconscious bias.

**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 are not complacent and recognise the importance of ensuring that the make-up of the sub-committees reflects the consultant body as closely as possible. In particular, we look at the gender and ethnicity of members.

Gender

NHS Digital equality and diversity statistics at 31 March 2017 (when our 2017 competition was open) show that 35.2% of the consultant population in England at that time was female. For each regional sub-committee with its target membership of 24 to be representative of this wider population, it would have 8 or 9 (8.5) female members.

Table 1 shows that of the fifteen sub-committees, only four had proportionate representation of women. Five sub-committees had less than 25% female representation: East of England, London Northeast, Northwest England, Southeast England; and Southwest England. In addition, only 1 Medical Vice-Chair and only 2 Chairs were women.

**Table 1 – Sub-committee membership by gender**

| | Male | Female | Total | %F |
|---|---|---|---|---|
| **Department of Health** | 6 | 9 | 15 | 60.0% |
| **Cheshire and the Mersey** | 16 | 8 | 24 | 33.3% |
| **East Midlands** | 17 | 6 | 23 | 26.1% |
| **East of England** | 17 | 4 | 21 | 19.0% |
| **London Northeast** | 22 | 5 | 27 | 18.5% |
| **London Northwest** | 15 | 9 | 24 | 37.5% |
| **London South** | 16 | 9 | 25 | 36.0% |
| **Northeast** | 16 | 7 | 23 | 30.4% |
| **Northwest** | 22 | 4 | 26 | 15.4% |
| **South** | 16 | 7 | 23 | 30.4% |
| **Southeast** | 18 | 5 | 23 | 21.7% |
| **Southwest** | 20 | 5 | 25 | 20.0% |
| **West Midlands** | 16 | 6 | 22 | 27.3% |
| **Yorkshire and the Humber** | 17 | 6 | 23 | 26.1% |
| **Wales** | 14 | 6 | 20 | 30.0% |
| **Total** | 248 | 96 | 344 | 27.9% |

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

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

Ethnicity

Likewise, according to NHS Digital equality and diversity statistics, to mirror the overall consultant population, our sub-committees would, on average, be 59% white**.** We do not have an equivalent accurate picture of the 2017 membership's ethnicity and commit to improving our membership diversity data, but we acknowledge there remains under-representation of people from Black, Asian and Minority Ethnic (BAME) backgrounds despite our efforts to recruit BAME members.

---

With the sub-committee Chairs and Medical Vice-Chairs, we will continue to encourage female and BAME consultants to join the sub-committees. We invite the Medical Royal Colleges, Specialist Societies and NHS employers to help us to achieve this aim. Increasing the diversity of the sub-committees will lead to increased diversity of Chairs and Medical Vice-Chairs as the pool of candidates broadens.

## 1.4 2017 operational issues and changes

**Secretariat**

The ACCEA Secretariat is made up of Civil Servants and hosted by the Department of Health and Social Care. Towards the end of 2016, the Department underwent a major reorganisation. This led to the staff in the London-based ACCEA Secretariat moving on between January and February 2017, to be replaced by a new, smaller Leeds-based team.

This presented challenges for the organisation, but the knowledge and experience of the then Chair, the Medical Director and of the Sapient IT support team helped the incoming staff quickly to become operational. There were no major issues caused by this change in personnel.

**Information Technology**

Sapient continued to provide coding and application support to ACCEA over 2017/18 as part of its G-Cloud contract with DHSC. Towards the end of 2017, as the new ACCEA Secretariat is based in Leeds, Sapient moved our IT support team to be co-located with them.

Overall, the ACCEA online application system and awards database and its host servers stood up well to the volume of traffic received during the application window. It was only unavailable for a period of two-and-a-half hours due to a server fault.

Following the 2017 application window and our contact with consultants, their employers and other customers, we worked with Sapient to make changes to the online system to improve user experience and operational effectiveness. Amongst other changes, we:

- Introduced a new category of system user: ‘responsible users’ – These are the people within a Trust who have day-to-day responsibility for CEAs and with whom, in addition to Chief Executives, we need to communicate;
- Included additional information on unsuccessful renewal applications (and applications expected but not received) on our awards outcome communications, helping employers to manage awards payments more easily;
- Added a new system-generated e-mail template allowing us to advise consultants ahead of the application window that the renewal of their award is forthcoming;
- Introduced self-service password and user-name resets to reduce the need for consultants to contact ACCEA from the 2018 round onwards, saving everyone’s time;
- Introduced administrator-configurable messages that users can see when they log in, giving ACCEA another means of communicating with customers; and
- Removed the ‘withdraw application’ button that would irreversibly delete a consultant’s application and which was used in error during the 2017 application round.

Separately, working with Atos, who supply DHSC's Information Technology, we also changed the operation of our customer-facing telephone line. We:

- Implemented standard office hours of 08:30 to 17:00 Monday to Friday and an out-of-hours message;
- Abolished our out-of-hours voicemail, messages from which customers would almost always follow-up with an e-mail; and
- Introduced a text-to-voice message that allows us to communicate key service information upfront.

**Main Committee decisions**

Main Committee met in November 2017 to review the outcomes from the sub-committees' scoring and from NRES and to make final recommendations to Ministers for new and renewed English national CEAs. The Committee also discussed issues that had arisen during the round and advised on amendments to the guidance and application forms.

Consultant remuneration

Consultants and academic GPs are often appropriately involved in wider roles that attract additional rewards. Examples of such roles and payments include:

- Editorial payments;
- Roles in private companies (such as directorships);
- Shareholdings in private companies;
- Consultancy fees; and
- Lecture fees or chairing conference sessions.

During the awards round, the question arose of whether taxpayer-funded CEAs should be awarded for activities in which applicants already have a private financial interest.

ACCEA has no wish to stifle this valuable work, but believes that applicants should be open and transparent about the sources of their wider earnings in their applications. Our scorers can then assess whether the remunerated activities should count towards a CEA.

Main Committee agreed with the recommendation that we account for financial interests in a way that maintains the integrity of the national CEA process, but does not discourage consultants from undertaking additional activity.

Trusts in special measures

As part of the due diligence process for new awards and renewals, ACCEA asks the Care Quality Commission (CQC) to confirm which Trusts are in special measures and to review the names of those consultants who are due to secure an award working at those Trusts.

During the 2017 checks, CQC expressed concerns about awarding national CEAs to consultants working for special measures Trusts. The regulator recommended that such awards only be made exceptionally.

ACCEA recommended that the list of proposed awards stand because:

- Any concerns about an applicant's performance should be aired when the Chief Executive signs off an application;
- CEAs are granted following rigorous scrutiny of the evidence submitted in applications. The consultants' applications had been successful following a fair and transparent process;
- ACCEA's Chair (William Worth) and Medical Director had reviewed the applications of the consultants concerned and supported the sub-committees' decisions; and
- The General Medical Council and General Dental Council had raised no concerns in relation to the consultants listed.

Main Committee was reminded that a similar debate had taken place in 2013 following the events at Mid-Staffordshire and that the Committee's decision was not to penalise individuals.

The Committee noted the Chair (William Worth)'s commitment that ACCEA would continue to give careful consideration to applications from consultants with management roles in Trusts in special measures. Main Committee also agreed that the awards should stand and that ACCEA's documentation should be strengthened to require Chief Executives of Trusts in special measures explicitly to address this question as part of the employer statement.

## 1.5 2017 organisational finances

During 2017/18, 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) £47,139 to £58,476
- 1x Service Manager (SEO, DHSC) £35,043 to £42,269
- 2x Service Officer (EO, DHSC) £22,309 to £26,775
- 1x Temp Administrative Officer (AO, Brook Street) Rate not disclosed

These ranges exclude any superannuation (pension costs) and National Insurance contributions.

Our sub-committee lay members are eligible to claim an allowance for their scoring and for travel and expenses. Over 2017/18, 88 members were eligible and they claimed a total of £79,543.83. The Chair and Medical Director are also entitled to claim for travel and expenses. In 2017/18, this totalled £4,298.15.

Finally, we maintain an online application system and awards database. In 2017/18, Sapient's G-Cloud (government procurement framework) contract to develop the system was extended by one year. This contract was worth £505,983.30. The application was hosted by Atos as part of its wider IT Services contract with DHSC and it is not possible to separate out ACCEA's costs.

As ACCEA is embedded within the Department of Health and Social Care, it is not possible to split out figures on ACCEA Secretariat travel and expenses or our office accommodation and information technology costs. These are reported as part of the parent organisation's reports and accounts.

# Part 2: the 2017 Awards Round

## 2.1 Finances of national CEAs

**Funding flows**

ACCEA itself only holds the budget for awards paid to consultants who work for NHS Blood and Transplant, which are transferred through invoice/purchase order. Monies for National Institute for Health and Care Excellence- (NICE), Public Health England- and Health Education England- based consultants are baselined within those organisations' budgets and the totals allocated then adjusted to reflect actual spend.

Most English awards – those for consultants who work for NHS England and NHS Trusts – are funded from NHS England's budget. NHS England's central finance team sends our awards payment information to its regional finance teams which then raise purchase orders against which Trusts can invoice. Any universities employing an academic consultant with a CEA recover their costs by invoicing the Trust that holds the consultant's honorary contract.

Welsh awards are funded to Local Health Boards by the Welsh Government. Again, universities employing academic consultants can recover their costs from the relevant NHS organisation.

**Award values 2017/18**

Awards payments are adjusted based on the number of programmed activities (PAs) an award holder undertakes. For most consultants, we consider ten PAs to be full time, but for academics, five or more PAs attract the full award value. Awards are paid annually for five years.

For 2017/18, awards were uplifted by 1% as recommended by the Pay Review Body on Doctors' and Dentists' Remuneration (DDRB).

In addition to the awards, as national awards are pensionable, we also fund the on-costs. For non-academics, these are rated at 27.8% and for academics at 29.0%. The values of full awards and on-costs for clinical consultants and academic consultants are shown in Tables 2 and 3 respectively.

**Table 2 – CEA values in 2017/18 with clinical consultant on-costs**

| Full time consultants (10+PAs) | Award value | On-costs at 27.8% | Total |
|---|---|---|---|
| **Bronze** | £36,192 | £10,061 | £46,253 |
| **Silver** | £47,582 | £13,228 | £60,810 |
| **Gold** | £59,477 | £16,535 | £76,012 |
| **Platinum** | £77,320 | £21,495 | £98,815 |

**Table 3 – CEA values in 2017/18 with academic consultant on-costs**

| Full time academic consultants (5+PAS) | Award value | On-costs at 29.0% | Total |
|---|---|---|---|
| **Bronze** | £36,192 | £10,496 | £46,688 |
| **Silver** | £47,582 | £13,799 | £61,381 |
| **Gold** | £59,477 | £17,248 | £76,725 |
| **Platinum** | £77,320 | £22,423 | £99,743 |

Tables 4 and 5 detail the financial allocations made in 2017/18 and the numbers of existing and new awards at each award level at January 2018.

**Table 4 – Total value of CEAs in 17/18**

| Awards Round | Financial Year | Wales | England | Total |
|---|---|---|---|---|
| **2017** | **2017/18** | £6,946,129 | £136,548,561 | £143,494,690 |

**Table 5 – Awards in payment (England and Wales) January 2018**

| **Total** | | | |
|---|---|---|---|
| 2601 awards | | | |
| Of which | | | |
| **Bronze awards** | **Silver awards** | **Gold awards** | **Platinum awards** |
| 1378 | 816 | 264 | 143 |
| and | | | |
| **New awards** | **Successful renewals** | **Existing awards** (not renewed in 2017) | |
| 318 | 235 | 2048 | |

## 2.2 2017 renewal applications

During the 2017 awards round, we received 418 applications for the renewal of national Clinical Excellence Awards. Table 6 shows the outcome of those applications. 72.4% of applicants succeeded in either renewing their awards at the same level or in securing a higher award. 5.3% of applicants did not score enough to renew at their existing award level, but maintained a national award. Only 22.2% of applicants were completely unsuccessful.

**Table 6 – Renewal outcomes 2017**

| | No | % Total |
|---|---|---|
| **Successful renewals** | 235 | 56.2% |
| **(Of which renewed at a lower level)** | (22) | (5.3%) |
| **Applicants renewing and successful at higher level** | 90 | 21.5% |
| **Unsuccessful renewals** | 93 | 22.2% |
| **Total Renewal Applications** | 418 | 100.0% |

Table 7 shows that of the 22 applicants who renewed at a lower level, nearly all dropped one level.

**Table 7 – Renewals at lower levels 2017**

| | |
|---|---|
| **Moved from Silver to Bronze** | 8 |
| **Moved from Gold/A to Silver** | 5 |
| **Moved from Gold to Bronze** | 1 |
| **Moved from Platinum/A+ to Gold** | 8 |
| **Total** | 22 |

Of the unsuccessful renewal applications, the vast majority were at bronze level (as shown by Table 8). As already shown, there are progressively fewer awards in payment the higher the award level, so this can, to a certain extent, be expected. Nevertheless, bronze applicants were proportionately significantly less likely to secure renewal, with 31.2% unsuccessful compared to 7.1% on average across all the other award levels.

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. So, the quality and volume of applications for those new awards are factors in renewal success.

**Table 8 – Unsuccessful renewals by level 2017**

| | Unsuccessful | Total applications | % Unsuccessful |
|---|---|---|---|
| **Platinum/A Plus** | 1 | 20 | 5.0% |
| **Gold/A** | 3 | 32 | 9.4% |
| **Silver** | 7 | 103 | 6.8% |
| **Bronze/B** | 82 | 263 | 31.2% |
| **Total/Overall** | 93 | 418 | 22.2% |

However, we cannot necessarily link levels of success to levels of competition (see Table 17 for numbers of applications for new awards). Table 9 shows that there were higher unsuccessful renewal rates in London Northeast, where there were 51 new bronze applications, and in Cheshire and the Mersey, where there were only 19. In addition, there were 49 new bronze applications in the Northwest, and no unsuccessful renewals.

**Table 9 – Unsuccessful renewals by sub-committee 2017**

| | Unsuccessful | Total applications | % Unsuccessful |
|---|---|---|---|
| **Department of Health** | 1 | 8 | 12.5% |
| **Cheshire and the Mersey** | 6 | 15 | 40.0% |
| **East Midlands** | 5 | 27 | 18.5% |
| **East of England** | 8 | 29 | 27.6% |
| **London Northeast** | 16 | 42 | 38.1% |
| **London Northwest** | 1 | 22 | 4.5% |
| **London South** | 13 | 41 | 31.7% |
| **Northeast** | 4 | 22 | 18.2% |
| **Northwest** | 0 | 23 | 0.0% |
| **South** | 7 | 32 | 21.9% |
| **Southeast** | 4 | 16 | 25.0% |
| **Southwest** | 9 | 37 | 24.3% |
| **West Midlands** | 8 | 33 | 24.2% |
| **Yorkshire and the Humber** | 5 | 32 | 15.6% |
| **Wales** | 5 | 19 | 26.3% |
| **Platinum** | 1 | 20 | 5.0% |
| **Total** | 93 | 418 | 22.2% |

## 2.3 Analysis of 2017 new awards

**Diversity**

At ACCEA, we strongly believe in taking all necessary steps to achieve equality and diversity, taking our legal responsibilities very seriously. Broadly, these are to have regard to the need to: eliminate discrimination; advance equality; and foster good relations between groups.

In order to ensure that our process remains fair and unbiased (in accordance with these duties), we look at statistics, including application rates and success rates for different groups.

Age

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 Clinical Excellence Awards is such that consultants must progress from a bronze award (or local level 9) through a silver, then a gold, to a platinum award.

This means that we would expect the average age of award holders to increase with the award level.

**Table 10 – Average age of successful 2017 applicants for a new award at April 2017 by award level**

| Level | Mean age (years) |
|---|---|
| **Bronze** | 50.0 |
| **Silver** | 53.7 |
| **Gold** | 56.0 |
| **Platinum** | 57.0 |

This is borne out by analysis of the 2017 round. Table 10 shows that the mean successful applicant age increases with the award level, although the difference between the average age of the year's bronze and platinum awardees is only seven years. The youngest successful bronze applicants were 36-40 and the oldest successful platinum applicant was 66-70.

**Table 11 – 2017 applications and success rate for new awards by age group**

| | | Bronze | Silver | Gold | Platinum | Total |
|---|---|---|---|---|---|---|
| **36-40** | **Applications** | 16 | - | - | - | 16 |
| | **Awards** | 3 | - | - | - | 3 |
| | **Success rate** | 18.8% | - | - | - | 18.8% |
| **41-45** | **Applications** | 82 | 2 | - | - | 84 |
| | **Awards** | 29 | 1 | - | - | 30 |
| | **Success rate** | 35.4% | 50.0% | - | - | 35.7% |
| **46-50** | **Applications** | 153 | 63 | 6 | - | 222 |
| | **Awards** | 52 | 26 | 1 | - | 79 |
| | **Success rate** | 34.0% | 41.3% | 16.7% | - | 35.6% |
| **51-55** | **Applications** | 160 | 168 | 43 | 7 | 378 |
| | **Awards** | 44 | 57 | 15 | 3 | 119 |
| | **Success rate** | 27.5% | 33.9% | 34.9% | 42.9% | 31.5% |
| **56-60** | **Applications** | 95 | 137 | 64 | 14 | 310 |
| | **Awards** | 23 | 31 | 14 | 5 | 73 |
| | **Success rate** | 24.2% | 22.6% | 21.9% | 35.7% | 23.5% |
| **61-65** | **Applications** | 17 | 25 | 13 | 4 | 59 |
| | **Awards** | 2 | 8 | 3 | 0 | 13 |
| | **Success rate** | 11.8% | 32.0% | 23.1% | 0.0% | 22.0% |
| **66-70** | **Applications** | 2 | 1 | 1 | 4 | 8 |
| | **Awards** | 0 | 0 | 0 | 1 | 1 |
| | **Success rate** | 0.0% | 0.0% | 0.0% | 25.0% | 12.5% |
| **71 and over** | **Applications** | 1 | - | - | - | 1 |
| | **Awards** | 0 | - | - | - | 0 |
| | **Success rate** | 0.0% | - | - | - | 0.0% |

Table 11 shows that whilst advancing age is no barrier to application, the success rate for bronze and silver applicants first reduces significantly from age 51 to 55. At gold, this dip occurs at age 56 to 60. At platinum level there are so few applications that it is difficult to draw statistically significant conclusions.

Gender

In the past year, there has rightly been a focus on the gender pay gap in the UK economy, which we agree is an important issue. In medicine, coverage has commented on the facts that Clinical Excellence Awards magnify the effect of the gender pay gap and that the clear majority of awards go to men.

Examining just the numbers of new awards made to both genders in 2017, there is a stark difference: 259 awards were given to men and only 59 to women. However, this is not the full picture.

As shown in our recent Annual Reports, when female consultants do apply, their percentage success rate is generally comparable to the success rates of their male colleagues. Table 12 shows that in 2017, 30.3% of male applicants received new awards, compared to 26.8% of female applicants.

**Table 12 – 2017 applications and success rate by gender**

| | Applicants n | Applicants % | Awards n | Awards % | Success rate |
|---|---|---|---|---|---|
| **Female** | 221 | 20.5% | 59 | 18.6% | 26.7% |
| **Male** | 857 | 79.5% | 259 | 81.4% | 30.2% |
| **Total** | 1078 | 100.0% | 318 | 100.0% | 29.5% |

The closeness of the success rates of male and female applicants over the last five years (as shown in Table 13), reassure us that our scoring mechanism and the sub-committees carrying out the scoring are not biased towards either gender. In order further to protect against bias, we continue to focus on recruiting more women onto ACCEA's regional sub-committees (see the Diversity of sub-committees section).

However, the key disparity between the genders is that women consultants are greatly under-represented as a proportion of applicants.

**Table 13 – Success rates by gender 2013 to 2017**

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

NHS Digital equality and diversity statistics at 31 March 2017 (when our 2017 competition was open) show that 35.2% of the consultant population in England at that time was female. However, whilst any eligible consultant can put him or herself forward for a national Clinical Excellence Award, only 20.5% of (English and Welsh) applicants to the 2017 national Clinical Excellence Awards competition were female.

This under-representation of female applications is exacerbated at higher award levels as award holders must progress from bronze (or local level 9) to silver to gold to platinum (see Table 14).

**Table 14 – Success rate by gender and award level**

| Level | Gender | Applications | % Apps at Level | Awards | % Awards at Level |
|---|---|---|---|---|---|
| **Bronze** | **Male** | 388 | 73.8% | 116 | 75.8% |
| | **Female** | 138 | 26.2% | 37 | 24.2% |
| **Silver** | **Male** | 317 | 80.1% | 102 | 83.6% |
| | **Female** | 79 | 19.9% | 20 | 16.4% |
| **Gold** | **Male** | 106 | 83.5% | 28 | 84.8% |
| | **Female** | 21 | 16.5% | 5 | 15.2% |
| **Platinum** | **Male** | 25 | 86.2% | 8 | 88.9% |
| | **Female** | 4 | 13.8% | 1 | 11.1% |

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. As we meet with our sub-committees during the 2018 round, we will seek regional perspectives on why women are less likely to apply and ask for their help.

The Department of Health and Social Care has commissioned an independent report to examine how doctors – regardless of their gender – can be rewarded fairly for their work. Prof Dame Jane Dacre, former President of the Royal College of Physicians, is leading this review into the gender pay gap in medicine and Prof Carol Woodhams from the University of Surrey is its lead researcher. The review is examining why the gap exists and aims to identify the obstacles that may prevent female doctors from progressing in their careers. It is also considering the impact of having children, working patterns, care arrangements, access to flexible working, shared parental leave, the predominance of men in senior roles and the impact of 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 Clinical Excellence Awards *are* asked to declare their ethnicity, however, our scorers do not have access to this data.

Looking at statistics on ethnicity from the 2017 round (Table 15), we can see that consultants from Black, Asian and Minority Ethnic (BAME) backgrounds applying for new awards received 20.1% of the awards, whilst they represented 22.6% of the applications. Although there is some variation by different award level, the overall success rates are consistent with application levels. Actual numbers could differ as 4.5% of applicants did not declare their ethnicity.

**Table 15 – 2017 applications and success rate by ethnicity and award level**

| Level | Ethnicity | Applications | % Apps at Level | Awards | % Awards at Level |
|---|---|---|---|---|---|
| **Bronze** | **White** | 359 | 68.3% | 105 | 68.6% |
| **Bronze** | **BAME** | 140 | 26.6% | 38 | 24.8% |
| **Bronze** | **Not Stated** | 27 | 5.1% | 10 | 6.5% |
| **Silver** | **White** | 303 | 76.5% | 99 | 80.5% |
| **Silver** | **BAME** | 75 | 18.9% | 18 | 14.6% |
| **Silver** | **Not Stated** | 18 | 4.5% | 6 | 4.9% |
| **Gold** | **White** | 103 | 81.1% | 23 | 69.7% |
| **Gold** | **BAME** | 21 | 16.5% | 7 | 21.2% |
| **Gold** | **Not Stated** | 3 | 2.4% | 3 | 9.1% |
| **Platinum** | **White** | 22 | 75.9% | 8 | 88.9% |
| **Platinum** | **BAME** | 7 | 24.1% | 1 | 11.1% |
| **Platinum** | **Not Stated** | - | - | - | - |
| **Overall** | **White** | 787 | 73.0% | 235 | 73.9% |
| **Overall** | **BAME** | 243 | 22.5% | 64 | 20.1% |
| **Overall** | **Not Stated** | 48 | 4.5% | 19 | 6.0% |

Again, analysing the success rates and application rates over many years (Table 16), we believe that scoring is fair and unbiased and that ethnicity is not a factor. Nevertheless, we are not complacent and will continue to analyse and review the success rate of BAME applicants, and work to make our sub-committee membership more representative of the consultant population (see the Diversity of sub-committees section).

**Table 16 – Success rate of consultants from Black, Asian and Minority Ethnic Backgrounds 2013 to 2017**

| | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|
| **Total applications** | 1816 | 1539 | 1198 | 1200 | 1078 |
| **Applications from BAME consultants** | 313 | 285 | 229 | 252 | 243 |
| **% of total** | 17.2% | 18.5% | 19.1% | 21.0% | 22.5% |
| **Total awards** | 317 | 318 | 317 | 318 | 318 |
| **Awards made to BAME consultants** | 53 | 38 | 66 | 66 | 64 |
| **% of total** | 16.7% | 11.9% | 20.8% | 20.8% | 20.1% |
| **Difference** | 0.5% | 6.6% | -1.7% | 0.2% | 2.4% |

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 from 31 March 2017 tell us that 35.4% of consultants were non-white (5.0% of consultants did not state their ethnicity and 0.7% of consultants'

ethnicity is unknown), whereas, as already stated, only 22.5% of applicants for new CEAs in 2017 were consultants from BAME backgrounds.

We will continue to encourage applications from all sectors of the consultant body 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.

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

ACCEA does not collect data on these protected characteristics as applicants' statuses within these characteristics are significantly 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**

Aside from ensuring the diversity of awards recipients, ACCEA also looks to ensure that awards are fairly distributed across the English regions and Wales. We also like to see that a wide range of medical specialties (and dentistry and public health) are 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.

Table 17 (on the next page) shows that across England the outcome is broadly equitable, with each region achieving a success rate close to the overall success rate of 29.5%, acknowledging that in small regions or at the higher levels where there are fewer applications numbers are small, the success rates can vary more significantly. 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 also monitors the distribution of new awards and application numbers across the specialties, but we do not hold information on the numbers of eligible consultants in each specialty. Where we believe that specialties are under-represented in terms of number of applications, we seek the help of the relevant professional body or Royal College to encourage more applications. At the end of each application round, we hold a detailed feedback meeting with the National Nominating Bodies, to present the outcome and to discuss ways which we can collectively help those specialties that are less successful.

**Table 17 – 2017 applications and success rate by ACCEA sub-committee**

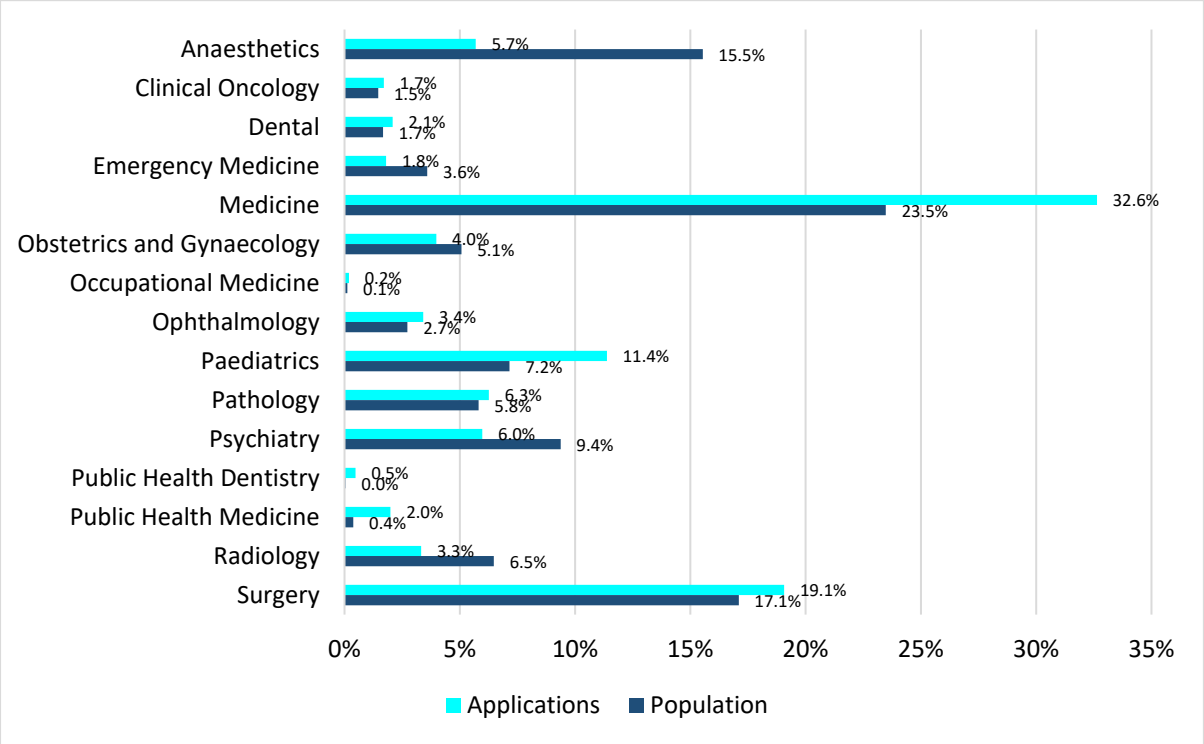
| | Bronze | | | Silver | | | Gold | | | Platinum | | | Total/Overall | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sub-committee | Applic-ations | Awards | Success rate | Applic-ations | Awards | Success rate | Applic-ations | Awards | Success rate | Applic-ations | Awards | Success rate | Applic-ations | Awards | Success rate |
| Department of Health | 15 | 5 | 33.3% | 12 | 4 | 33.3% | 1 | 0 | 0.0% | - | - | - | 28 | 9 | 32.1% |
| Cheshire and the Mersey | 19 | 6 | 31.6% | 9 | 3 | 33.3% | 5 | 1 | 20.0% | - | - | - | 33 | 10 | 30.3% |
| East Midlands | 36 | 10 | 27.8% | 22 | 6 | 27.3% | 8 | 2 | 25.0% | - | - | - | 66 | 18 | 27.3% |
| East of England | 26 | 8 | 30.8% | 19 | 7 | 36.8% | 9 | 2 | 22.2% | - | - | - | 54 | 17 | 31.5% |
| London Northeast | 51 | 16 | 31.4% | 40 | 11 | 27.5% | 19 | 5 | 26.3% | - | - | - | 110 | 32 | 29.1% |
| London Northwest | 29 | 9 | 31.0% | 27 | 8 | 29.6% | 7 | 2 | 28.6% | - | - | - | 63 | 19 | 30.2% |
| London South | 51 | 16 | 31.4% | 32 | 10 | 31.3% | 10 | 3 | 30.0% | - | - | - | 93 | 29 | 31.2% |
| Northeast | 31 | 9 | 29.0% | 36 | 11 | 30.6% | 5 | 1 | 20.0% | - | - | - | 72 | 21 | 29.2% |
| Northwest | 49 | 14 | 28.6% | 26 | 7 | 26.9% | 13 | 3 | 23.1% | - | - | - | 88 | 24 | 27.3% |
| South | 24 | 9 | 37.5% | 31 | 9 | 29.0% | 10 | 3 | 30.0% | - | - | - | 65 | 21 | 32.3% |
| Southeast | 31 | 8 | 25.8% | 19 | 7 | 36.8% | 5 | 1 | 20.0% | - | - | - | 55 | 16 | 29.1% |
| Southwest | 36 | 9 | 25.0% | 36 | 11 | 30.6% | 10 | 3 | 30.0% | - | - | - | 82 | 23 | 28.0% |
| West Midlands | 28 | 11 | 39.3% | 32 | 9 | 28.1% | 8 | 2 | 25.0% | - | - | - | 68 | 22 | 32.4% |
| Yorkshire and the Humber | 42 | 13 | 31.0% | 41 | 13 | 31.7% | 13 | 4 | 30.8% | - | - | - | 96 | 30 | 31.3% |
| Platinum | - | - | - | - | - | - | - | - | - | 29 | 9 | 31.0% | 29 | 9 | 31.0% |
| Wales | 58 | 10 | 17.2% | 14 | 7 | 50.0% | 4 | 1 | 25.0% | - | - | - | 76 | 18 | 23.7% |
| Total/Average England | 468 | 143 | 30.6% | 382 | 116 | 30.4% | 123 | 32 | 26.0% | 29 | 9 | 31.0% | 1002 | 300 | 29.9% |
| Total/Average E+W | 526 | 153 | 29.1% | 396 | 123 | 31.1% | 127 | 33 | 26.0% | 29 | 9 | 31.0% | 1078 | 318 | 29.5% |

**Table 18 – 2017 applications and success rate by specialty**

| | Bronze | | | Silver | | | Gold | | | Platinum | | | Total/Overall | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Specialty** | **Applic-ations** | **Awards** | **Success rate** | **Applic-ations** | **Awards** | **Success rate** | **Applic-ations** | **Awards** | **Success rate** | **Applic-ations** | **Awards** | **Success rate** | **Applic-ations** | **Awards** | **Success rate** |
| **Academic GP** | 12 | 5 | 41.7% | 7 | 5 | 71.4% | 5 | 1 | 20.0% | 0 | - | - | 24 | 11 | 45.8% |
| **Anaesthetics** | 24 | 8 | 33.3% | 23 | 4 | 17.4% | 10 | 1 | 10.0% | 3 | 0 | 0.0% | 60 | 13 | 21.7% |
| **Clinical Oncology** | 12 | 3 | 25.0% | 2 | 0 | 0.0% | 3 | 0 | 0.0% | 1 | 0 | 0.0% | 18 | 3 | 16.7% |
| **Dental** | 12 | 2 | 16.7% | 7 | 2 | 28.6% | 3 | 0 | 0.0% | 0 | - | - | 22 | 4 | 18.2% |
| **Emergency Medicine** | 14 | 1 | 7.1% | 4 | 1 | 25.0% | 1 | 0 | 0.0% | 0 | - | - | 19 | 2 | 10.5% |
| **Medicine** | 163 | 49 | 30.1% | 122 | 36 | 29.5% | 49 | 11 | 22.4% | 10 | 4 | 40.0% | 344 | 100 | 29.1% |
| **Obstetrics and Gynaecology** | 15 | 3 | 20.0% | 23 | 8 | 34.8% | 3 | 0 | 0.0% | 1 | 0 | 0.0% | 42 | 11 | 26.2% |
| **Occupational Medicine** | 1 | 0 | 0.0% | 1 | 0 | 0.0% | 0 | - | - | 0 | - | - | 2 | 0 | 0.0% |
| **Ophthalmology** | 18 | 10 | 55.6% | 13 | 4 | 30.8% | 4 | 1 | 25.0% | 1 | 1 | 100.0% | 36 | 16 | 44.4% |
| **Paediatrics** | 65 | 19 | 29.2% | 40 | 14 | 35.0% | 11 | 2 | 18.2% | 4 | 1 | 25.0% | 120 | 36 | 30.0% |
| **Pathology** | 30 | 11 | 36.7% | 21 | 6 | 28.6% | 13 | 7 | 53.8% | 2 | 0 | 0.0% | 66 | 24 | 36.4% |
| **Psychiatry** | 28 | 6 | 21.4% | 31 | 3 | 9.7% | 3 | 2 | 66.7% | 1 | 1 | 100.0% | 63 | 12 | 19.0% |
| **Public Health Dentistry** | 3 | 2 | 66.7% | 2 | 1 | 50.0% | 0 | - | - | 0 | - | - | 5 | 3 | 60.0% |
| **Public Health Medicine** | 6 | 2 | 33.3% | 12 | 3 | 25.0% | 2 | 1 | 50.0% | 1 | 0 | 0.0% | 21 | 6 | 28.6% |
| **Radiology** | 16 | 4 | 25.0% | 17 | 7 | 41.2% | 2 | 1 | 50.0% | 0 | - | - | 35 | 12 | 34.3% |
| **Surgery** | 107 | 28 | 26.2% | 71 | 29 | 40.8% | 18 | 6 | 33.3% | 5 | 2 | 40.0% | 201 | 65 | 32.3% |
| **Total/Average E+W** | 526 | 153 | 29.1% | 396 | 123 | 31.1% | 127 | 33 | 26.0% | 29 | 9 | 31.0% | 1078 | 318 | 29.5% |

Table 18 shows that, unsurprisingly, the largest volumes of applications come from the broader specialties of medicine and surgery. 50.1% of applicants belong to these disciplines and, in proportion, they received just under 52% of the awards. Paediatrics did similarly well, with 11.1% of the applications and 11.3% of the awards.

**Chart 1 - Proportion, by specialty, of applications for new awards versus E+W population 2017**




Source: NHS Digital March 2017 statistics for Doctors by Grade and Specialty, StatsWales Medical and Dental Staff by specialty and year October 2017. Note that this excludes academic GPs.

Chart 1 (which excludes academic GPs) tells us that, in terms of application numbers versus consultant population, despite recent improvements, anaesthetics and psychiatry continue to be under-represented. Anaesthetists make up 15.5% of the consultant body in England and Wales, but made up 5.7% of applicants. Psychiatrists are 9.4% of the consultant population and made 6 % of applications.

In terms of success rate, public health dentists were the most successful group, with 5 out of 8 (60.0%) applicants receiving an award. Even more impressive, perhaps, was the cohort of academic GPs, with 24 out of 35 (45.8%) receiving an award.

The least successful specialty continues to be emergency medicine, which is 3.6% of the consultant population and yet only secured 21 applications (1.8% of total), with only 2 (10.5%) of those being successful.

We will 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.

**Application numbers over time**

Over the last five years we have been giving unsuccessful applicants a breakdown of their scores across the domains and benchmarked against the scores of successful new award holders. As Chart 2 shows, application numbers for new national Clinical Excellence Awards, although they have stabilised somewhat since 2015, continue to fall. The 2010 halving of the number of new awards from nearly 600 to 300 and consequently initially increased competition may account for some of the drop between 2011 and 2014.

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 the award levels since 2011. Again, figures for the last three rounds suggest that numbers may now have stabilised. Competition, however, remains extremely fierce, with scores closely clustered around the cut-off points in each region and many excellent applicants narrowly failing to gain an award.

**Chart 2 – Applications by level from 2011 to 2017**

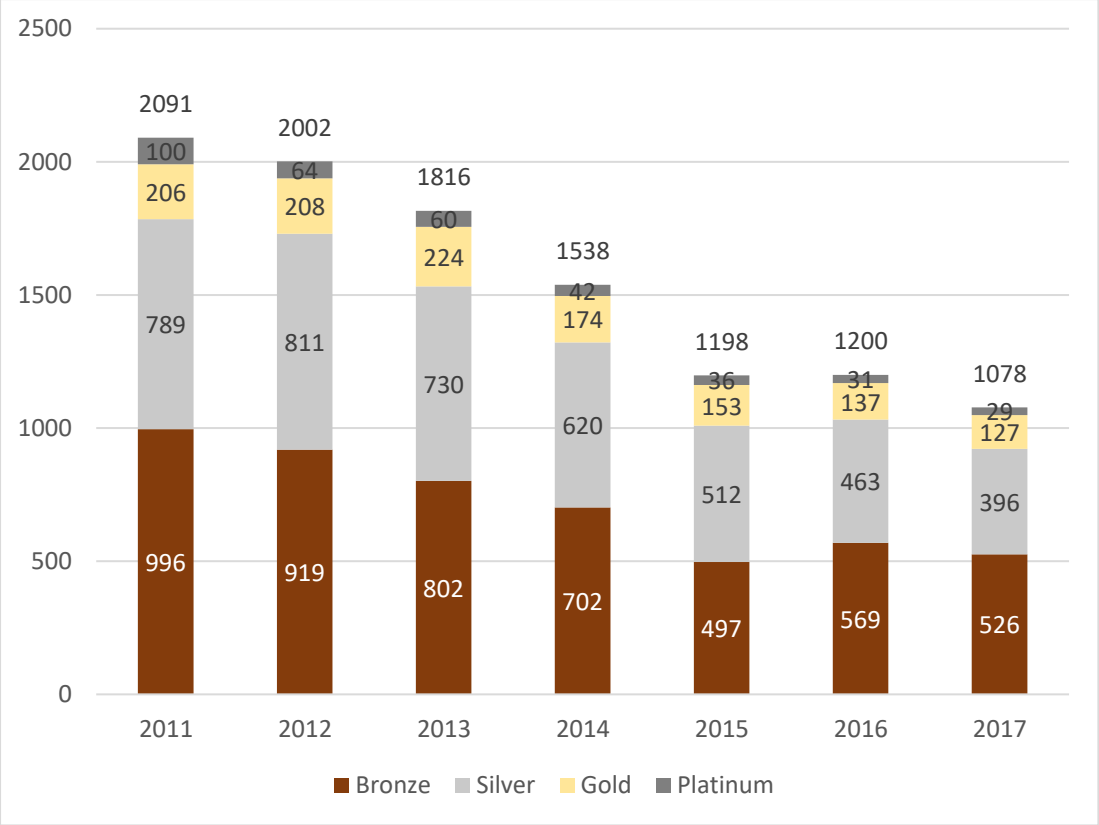
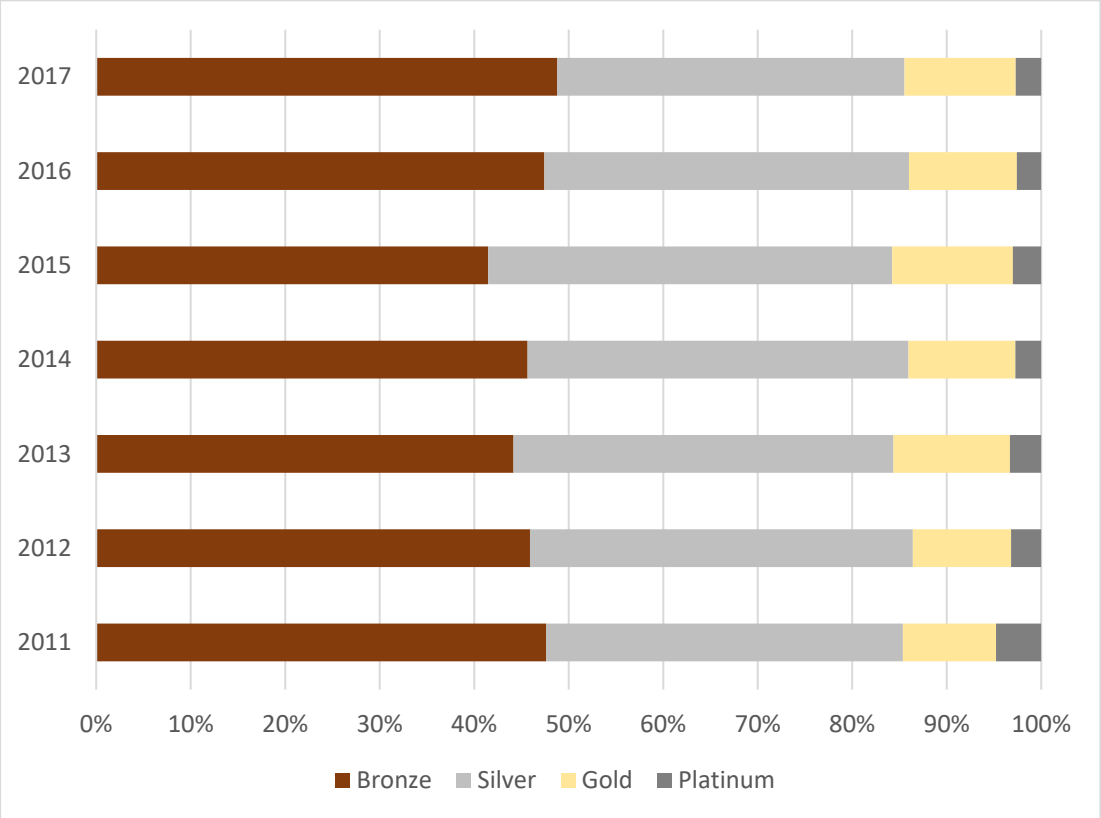


Chart 3 displays the proportion of the total number of applications received for each award level between 2011 and 2017. It shows that, bar a significant dip in the proportion of bronze applications in 2015 (the 29% decrease in bronze applications was proportionately larger than the decrease at other levels), the proportion of total applications at each award level has remained reasonably stable.

**Chart 3 – Percentage of applications for each award level from 2011 to 2017**



## 2.4 Appeals and concerns

Once each round is concluded, consultants can appeal. In 2017, applicants had until either Friday 25 January 2018 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.

Following the 2017 competition, ACCEA received 19 requests to appeal. These came from across 10 of the 13 English regions and from Wales. Grounds cited included:

Process-inherent issues:

- Different scores being provided for the same evidence (bronze renewal and silver new);
- Scores and success thresholds varying by region;
- Scores and success thresholds varying by year;
- Discrimination against applicants for renewal as their previous application is available for comparison (which is not the case).

Alleged sub-committee failures:

- 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 evidence presented;
- The sub-committee not coming to the same conclusion as the employer as to the suitability of the applicant for an award;
- The sub-committee being biased towards consultants who are known to the sub-committee;
- ACCEA procedural and sub-committee bias towards the teaching centre within the region.

Other issues:

- A CEA being refused when the applicant had received other national recognition;
- The failure of ACCEA to provide enough information to satisfy the applicant that due process was followed.

All requests to appeal were considered by the Chair, Medical Director and Secretariat and, after due consideration, none was considered to have sufficient grounds for appeal.

## 2.5 Outcome and assessment of the round

Our application window was open from 28 February to 26 April 2017, 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 1,076 applications for new awards and 418 applications for renewals.

Following 6 weeks of scoring, 26 sub-committee meetings across the country, involving over 325 scorers, and the National Reserve re-scoring exercise, 318 new awards, 212 successful renewals and 22 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 English awards, before the English and Welsh names were submitted to the respective Ministers.

In December 2017, the then UK Minister of State for Health, Philip Dunne MP, agreed the recommended English awards. In Wales, the Cabinet Secretary for Health and Social Services, Vaughan Gething AM, agreed the Welsh awards. Shortly before Christmas, ACCEA contacted consultants to make them aware of the outcome of their applications, similarly contacting their employers early in 2018, 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 and we will report on our progress next year.

**Equality and diversity:**

- We commit to improving our membership diversity data (see Diversity of sub-committees).
- With the sub-committee Chairs and Medical Vice-Chairs, we will continue to encourage female and BAME consultants to join the sub-committees. We invite the Medical Royal Colleges, Specialist Societies and NHS employers to help us to achieve this aim (see Diversity of sub-committees).
- As we meet with our sub-committees during the 2018 round, we will seek regional perspectives on why women are less likely to apply and ask for their help (see Diversity analysis).
- We will co-operate fully with the gender pay gap review (led by Prof Dame Jane Dacre), providing access to any relevant data as needed, and take seriously any recommendations it makes (see Diversity analysis).
- We will continue to analyse and review the success rate of BAME applicants, and 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 body 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 2017 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 open our training sessions to sub-committee members who have previously been unable to attend or who desire refresher training (see Scorers' training).
- We will also look at what additional content could be hosted on the sub-committee workspace, such as providing reference information on data handling and on avoiding unconscious bias (see Scorers' training).

- We will improve the way we account for applicants' financial interests, in a way that maintains the integrity of the CEA process, but does not discourage consultants from undertaking additional activity (see Main Committee decisions).
- We continue to give careful consideration to applications from consultants with management roles in Trusts in special measures and will strengthen our documentation to require Chief Executives of Trusts in special measures explicitly to address whether they support consultants' applications as part of the employer statement (see Main Committee decisions).

Published to GOV.UK in pdf format only.

Advisory Committee on Clinical Excellence Awards

www.gov.uk/accea