ACCEA

ADVISORY COMMITTEE on
CLINICAL EXCELLENCE AWARDS

Summer 2020 Focus Group Discussion Papers

Foreword

As you may be aware, the Advisory Committee on Clinical Excellence Awards (ACCEA) plans to run a full public consultation on the future of the national Clinical Excellence Awards (CEA) scheme. Subject to agreement from Ministers, we will be seeking views on the principal elements to adapt and reform its operation.

As we develop the new scheme, there are operational details that merit more in-depth discussion than may be achievable in a formal consultation exercise. We want to ensure that any new scheme fairly assesses and rewards the most deserving consultants and academic GPs, regardless of their background. We also want to build a scheme that is efficient, effective and user-friendly.

With this in mind, over the summer of 2020, we discussed five subjects with key stakeholders and our scoring sub-committee members via a series of Microsoft Teams-hosted videoconferences:

1 Improving the application process
2 Rankings and citations
3 Domains and scoring
4 Equality and diversity
5 Sub-committee structure

With thanks to attendees, we gathered much invaluable insight, but now want to ensure that all interested parties have the opportunity to feedback and not just those on our copy lists who were available to attend.

As such, we present the focus group discussion papers in this single document and invite written submissions from stakeholders and sub-committee members. If you have a contribution to make, please e-mail us at: accea@dhsc.gov.uk. We'd be grateful if you would title your message *Focus Group Written Submission* and make it clear whether it is a personal view or is sent on behalf of your organisation.

Thank you in anticipation,

Stuart Dollow and Kevin Davies

Chair and Medical Director

Advisory Committee on Clinical Excellence Awards

Contents

Focus Group 1 – Improving the application process

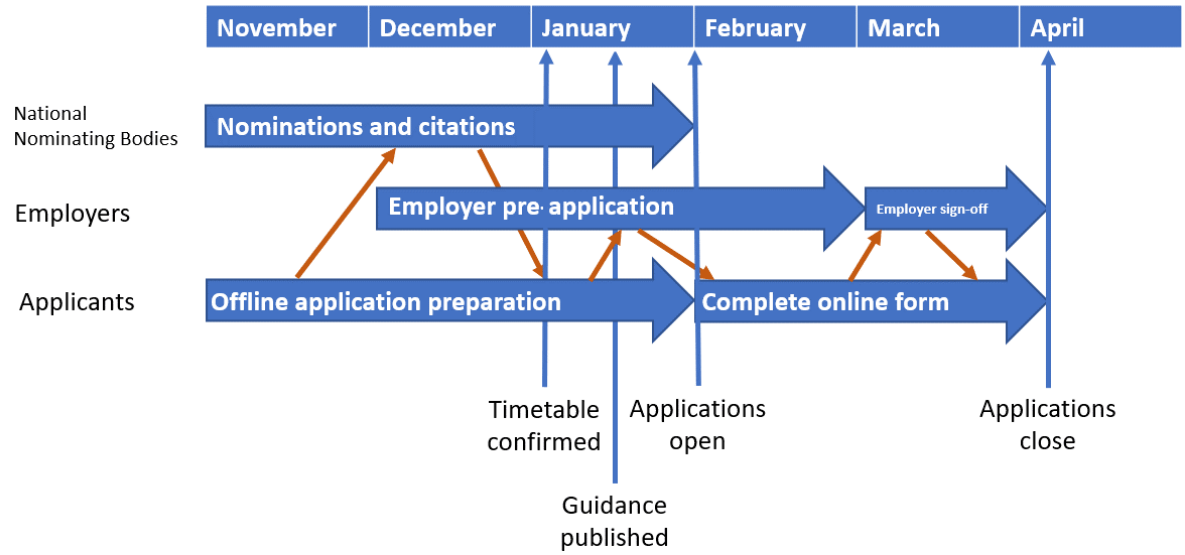
Each year, ACCEA administers the national Clinical Excellence Awards competition. The busiest time for all concerned is in the run-up to the application window and the window itself. ACCEA's secretariat, nominating bodies and specialist societies, employers and applicants are all active during this period of around four months.

It is important for the application process to be as straightforward and user-friendly as possible for all participants.

Questions:

1.1 Does the current phasing of pre-application, application and sign-off make sense?
1.2 Would you retain employer sign-off and, if so, what improvements would you make?
1.3 What kind of evidence or forward plan should applicants provide to demonstrate that they can maintain excellence for the duration of their award?

1.1 Application phasing



Two-month application window

From ACCEA's point of view, the application window is the two-month period between late January and early April during which applicants have access to the online application form.

During this time, applicants have to complete the form and send it to their employers for sign-off, before it is returned it to the applicant for submission to ACCEA. As such, the time available to the applicant to complete the form is dependent on the employer's submission deadline.

We know from experience that the large majority of sign-offs take place in the last two weeks of the application window, but this varies by employer.

Pre-application

We are also aware that the formal application window is only half of the story. Nominating bodies and specialist societies have their own procedures and deadlines for determining rankings and providing citations, largely in the month before applications open. These vary depending on the size of the organisation's membership. Thus, potential applicants often need to have decided to apply and to have drafted an application before the online application form is available.

Employers also have their own procedures in the run-up to an application. They will often canvas their consultant staff base in advance to gauge how many applications they will need to sign-off, ahead of timetabling and convening discussion panels.

Does the current phasing of pre-application, application and sign-off make sense?

1.2 Employer sign-off

We ask employers to sign-off and comment on each CEA application before it can be submitted. In the case of academic consultants and GPs, sign-off must be provided by the NHS organisation or Arm's Length Body holding their honorary contract. Whilst sign-off is in the name of the Chief Executive, it can be completed by a delegate.

This is to ensure that the consultant is providing a realistic view of their own performance and to understand their standing within their organisation.

Employer sign-off is in four sections:

Rating the evidence

The employer must rate the evidence presented against each of the five domains as one of the following:

- **X:** No contribution in this domain
- **U:** Has not delivered contractual expectations at a level expected
- **C:** Delivers contractual expectations
- **P:** Some aspects of delivery have been clearly over and above expectations
- **E:** Outstanding delivery of service

Commentary

The employer is invited to comment on the application and on the applicant's role within the organisation.

Support

The employer states that either: they do not support the application; they support it with qualification; or they support it. If unsupported or qualified support are selected, further information should be provided.

Checklist

The employer is asked a series of yes/no questions regarding job plans, appraisals, conduct and disciplinaries. Where an adverse selection is made, they are asked to provide details.

Would you retain employer sign-off and, if so, what improvements would you make?

1.3 Maintaining excellence

ACCEA is considering how, in recognising clinical excellence, progress can be maintained for the five-year period that the CEA is in place. At present, only evidence of recent past achievements is considered in the scoring of applications.

As part of the application process, we expect to ask applicants to provide a plan covering the five years for which, if successful, the CEA would be paid, in addition to the evidence of excellence they currently provide. This would show how they would maintain/continue to develop the work for which they are being recognised, thereby encouraging continued excellence during the period covered by the award. This could also form the basis for any future award application at the end of their five-year award period as only achievements during this period would be eligible for consideration.

What kind of evidence or forward plan should applicants provide to demonstrate that they can maintain excellence for the duration of their award?

Focus Group 2 – Rankings and Citations

An important part of the application process is the opportunity for applicants to receive support for their applications from significant individuals and organisations. This is achieved via the ranking and citation process.

Whilst only the evidence presented against the five evidence domains is marked, rankings and citations provide confirmation and contextualisation of that evidence. We want these processes to be both efficient and effective.

Questions:

2.1 How valuable do you find rankings and citations? If they are retained, how can the value of each be improved?
2.2 How might we simplify these processes?
2.3 What guidance should we give on best practice?

2.1 The value of rankings and citations

Rankings

Rankings (also called nominations) are submitted by National Nominating Bodies and Specialist Societies to indicate the level of their support for applications for new awards from within their membership. ACCEA regulates which organisations that are permitted to provide rankings and, from time-to-time, receives requests for an organisation to be added. Employers can provide rankings too, ranking applications from within their staff base. Rankings give scorers an idea of an applicant's standing within their employer, their profession and their specialty. They are used as a confirmation and contextualisation of the impact of the evidence submitted by the applicants.

Rankings are limited in number per award level depending on the size of the eligible membership:

- For Bronze Awards, the number of nominations will not exceed 0.6% of consultants with no national award.
- For Silver Awards, the number of nominations will not exceed 3.5% of the consultant member B/L9/Bronze award holders.
- For Gold Awards, the number of nominations will not exceed 3.5% of the consultant members holding Silver awards, or two - whichever is the larger.

So, ranking numbers vary, with the Royal College of Physicians (London) ranking 71 bronze applications in 2019 and (for example) the British Society of Paediatric Gastroenterology Hepatology and Nutrition, ranking 3.

Citations

Any individual or professional body may support an application for an award by submitting a citation. The citation should indicate the views of the individual or body on the quality and context of the applicant's contribution and ideally not duplicate the contents of the application. This additional information helps our scorers to verify and contextualise the evidence provided in the application. For academic consultants and GPs, they are part of the employer sign off and provide a key means for the substantive employer to comment.

However, in practice, as applicants have to seek their own citations, they may provide suggested text to the person or organisation from whom they are seeking support. Each year, this leads us to see several citations that are duplicated word-for-word and submitted on behalf of several different people/organisations. These duplicates are unhelpful as they place unnecessary burden on our scorers and, in the words of our previous Medical Director, 'less is more' suggesting a maximum of 5 citations be provided. We have also seen similar or identical citations provided for different applicants.

How valuable do you find rankings and citations? If they are retained, how can the value of each be improved?

2.2 Procedure

Pre-application

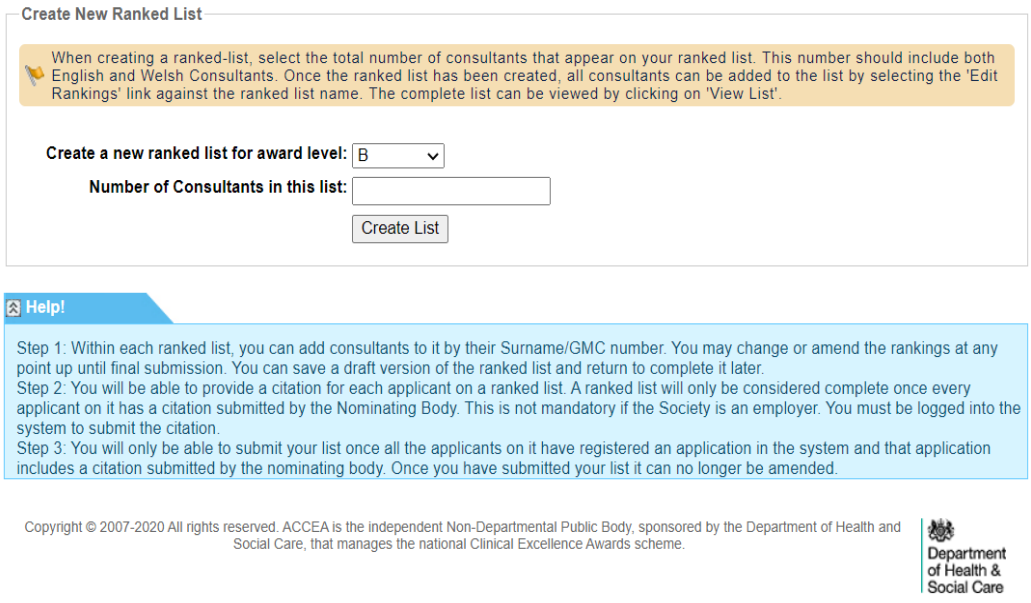
We are aware that National Nominating Bodies and Specialist Societies have their own internal procedures to determine rankings and generate citations. This is largely carried out in the month or so before applications open, although the timings may vary depending on the size of the organisation's membership and the resource dedicated to supporting applications.

In order to seek a ranking and citation, potential applicants often need to have decided to apply and to have drafted an application before the online application form or application guidance is available.

Ranking lists on the ACCEA system

Rankings can only be entered onto the ACCEA online system once the award round is open and the application has been begun. Rankings must be supported by a citation for each application ranked.

Nominators must create a ranked list for each award level and define the number of consultants to add to each, depending on the above formula and the number of applicants. They then add consultants to be ranked for that level and give each consultant a rank in the list.



Submitting a third-party citation

Once a consultant has begun their application, any third party can provide a citation by clicking 'Write Citation' on the ACCEA system login page and entering the applicant's GMC or GDC number.

How might we simplify these processes?

2.3 Best practice

Rankings and citations from nominators

We ask that all nominators operate open, objective and transparent systems for consideration of applications. It is good practice to involve consultants with and without a national award, and lay representatives. The process used should be publicised to all members in sufficient time to allow applicants to prepare applications and should provide for self-nomination.

Nominators' citations should evaluate the specialty or appropriate grouping and the impact on the wider NHS, rather than assessing contributions to the local employer, for which ACCEA receives direct, informed advice from employers.

Third-party citations

ACCEA recommends that citations should:

- All be different;
- Add to the evidence within the application rather than duplicating it;
- Be from people or organisations that are suitably distanced rather than from close colleagues;
- Be no more than five in number.

What guidance should we give on best practice?

Focus Group 3 – Domains and Scoring

The evidence domains are *the* most critical part of a national Clinical Excellence Award application. It is these five elements – and only these five – that are scored and which determine whether the application is successful.

However, the domains have not been reviewed in over a decade. As part of wider reforms to the CEA scheme, we want to take the opportunity to ensure the domains are up-to-date and allow applicants to demonstrate the quality of their achievements across the different facets of their work.

Questions:

3.1 Have you any views on our proposal to merge domains 1 and 2 and change the emphasis of current domains 3 to 5? What would you like to see in guidance? How detailed should applications be? Should we use additional forms and in which domains?

3.2 Should we have a domain of this type? If so, how might our proposed new domain 5 is be scored consistently? What guidance would be helpful?

3.3 How would you improve the scoring system?

3.1 The Five Domains

When completing an application for a national Clinical Excellence Award, consultants and academic GPs must detail their achievements and provide evidence of their performance in five domains. The current domains have not been substantially revised since Clinical Excellence Awards replaced Distinction Awards in 2004. As such, we are aware they may not fully reflect the range of modern consultant roles.

We want to ensure they can allow the applicant's evidence to reflect work and impact that is over-and-above their job role. They should also lead applicants to focus on national and international achievement, rather than local contribution.

The below descriptors are to inform our discussion and are subject to amendment.

<u>Domains 1 and 2</u>

> **Current: Delivering a high-quality service**
> Evidence should show achievements in delivering a service which is safe, has measurably effective outcomes, provides good patient experience, and where opportunities for improvement are consistently sought and implemented.
>
> **Current: Developing a high-quality service**
> Evidence should show how applicants have significantly enhanced clinical effectiveness (the quality, safety and cost effectiveness) of services locally and more widely within the NHS if this is the case.

There has long been conflation and overlap between these two domains, so we propose to merge them into one domain:

> **Proposed: Developing and delivering your service**
> Designing or redesigning a service and/or its delivery that has been widely adopted, boosting effectiveness within and beyond your locality, innovating, measuring and reviewing outcomes widely.

<u>Domain 3</u>

> **Current: Leadership and managing a high-quality service**
> Evidence should show how applicants have made a substantial personal contribution to leading and managing a local service, or national/international service or health policy development.

To further reduce confusion and overlap, we propose refocusing this domain. We would make it clearer that it can also be about leading people, changing it to:

> **Proposed: Leadership**
> Leading a service or developing significant policy above local and regional level, managing change, demonstrating an impact through leading people and cross-functional teams, developing vision and strategy, reaching across boundaries, making a difference through positions held.

Domain 4

Current: Research and innovation
Evidence should show how applicants have made a contribution to research or the evidence/evaluative base for quality or service innovation including the translation of evidence into practice.

We propose to swap the title of this domain around to make it more broad-based, with innovation as the focus and academic and clinical research contributing to, and enabling, innovation.

Proposed: Innovation and research
Bringing new ideas that benefit patient care into wide practice through, for example, researching new service models or use of technology in developing new models of care; carrying out trials and investigations; enabling others' research; making an impact through having a prominent status in a research field; publishing authoritative research findings that have been widely adopted.

Domain 5

Current: Teaching and training
Evidence should show how teaching and training forms a major part of the contribution applicants make to the NHS, over and above contractual obligations.

We propose to widen this domain to clarify that it is about more than formal tutelage. We think the proposed domain would now capture work that enables training and education; and less direct contributions to developing people beyond the employing organisation.

Proposed: Education, training and people development
Developing training widely, improving academic assessment, improving training resources and facilities beyond your locality, specialty and discipline, developing and publishing impactful learning materials, teaching and training diverse professional groups and/or the public.

Have you any views on the proposed domains? What would you like to see in guidance?

Application form

Currently, applicants have 1,350 characters (less than 650 words) in which to set out their evidence in each domain. Depending on the award level for which they apply, they have the option of submitting one, two or three additional forms, comprising:

- an additional 15,400 characters on Research and Innovation; and/or
- 6,750 on Teaching and Training; and/or
- 6,750 on Leadership and Management.

Under the proposed new scheme, there will be a single application for all tiers of award.

How detailed should the application form be: is the current length appropriate? Should we use additional forms? If so, in how many domains should they be permitted?

3.2 New Domain 5

If we merge existing domains 1 and 2, there will be space for a new domain 5. As new domains 1-4 are fairly specific, we want to ensure that new domain 5 is more dynamic, capturing evidence of working strategically and reflecting up-to-date pressures and priorities.

Our proposed new domain 5 would allow applicants to demonstrate excellence in an additional area, choosing the national or international strategies/priorities to which they have been contributing and submitting supporting evidence.

In England, this could include, for example:

a Care Quality Commission's inspection domains (safe; effective; caring; responsive to people's needs; and well-led) and/or
b NHS Long Term Plan priorities (new service models, action on prevention and health inequalities, such as by closing life expectancy gaps, care quality and outcomes, such as by improving the mental health of vulnerable groups, supporting NHS staff, harnessing digitally enabled care, optimising investment) and/or
c Secretary of State priorities: "people, prevention, infrastructure and technology" to improve patient care.

In Wales, this might be:

d Alignment to the Health and Care Standards (Staying Healthy, Safe Care, Effective care, Dignified Care, Timely Care, Individual Care)
e Healthier Wales (Development of patient care in new Health and Social Care Systems, Development of care systems moving care from the Hospital to Community Care, Development of and successful measurement of patient outcome measures leading to improved care.)

And/or:

f Other areas of impact as felt appropriate by the applicant.

Clearly, allowing the applicant to choose the subject of the domain poses challenges, both in terms of scorers' understanding of the chosen subject and in ensuring that all applications are comparable.

Should we have a domain of this type? If so, how might our proposed new domain 5 is be scored consistently? What guidance would be helpful?

3.3 Assessor Scoring

Currently, assessors are assigned to a scoring group, scoring either all the bronze, or all the silver and gold applications received from their sub-committee region. Platinum applications are scored by a national sub-committee.

Every sub-committee member scores independently. Once scoring opens, each assessor takes an initial overview of all the applications competing within a tier. Then, looking at each application in more detail, they examine the evidence presented against each of the five domains.

In doing so, they take account of any citations, any rankings and the employer rating and statement, which serve to verify and contextualise the evidence presented. Most crucially, they look at the applicant's job plan, assessing the evidence against the parameters of their employment, looking for excellence over-and-above what might be expected from fulfilling their role.

Finally, they assign one of the following scores against each domain:

- **10**: Excellent;
- **6:** Over and above contractual requirements;
- **2:** Meets contractual requirements;
- **0:** Does not meet contractual requirements or insufficient information to make a judgement;

giving a score out of 50. When scoring closes, each application's mean score is ranked against the others within the same tier and region.

In England, to ensure a consistent success rate across the awards tiers and regions, ACCEA assigns new awards to each tier within each scoring sub-committee region based on the number of applications. The top-ranked applications within each category are then provisionally assigned these awards, subject to sub-committee scrutiny; possible second stage tie-break and quality assurance (National Reserves, 'NRES') scoring; and Main Committee and ministerial sign-off.

Under the proposed new scheme, there would be a single application and the relative strength of the application would determine the award tier.

Whilst the current scoring rubric is designed to force scorers to make a clear choice in assessing the relative quality of the evidence presented, we also recognise that scores of 0 are rare, leaving the majority of applications scoring combinations of 2s, 6s and 10s. Having sufficient scorers in each group is therefore essential to differentiate robustly between the applicants.

Nevertheless, despite the range of totals that can be produced by up-to-twelve scorers scoring each of the five domains, a difference of less than 0.5 in mean score between applications can be the difference between success and failure. In addition, we frequently see ties at the cut-off that lead to re-scoring at NRES to ensure the most deserving applicants receive one of the limited number of awards. While we still expect any scoring system to require NRES or a similar process, we would be interested in considering alternative scoring systems that avoid central tendency or

regression to the mean, and enable us to recognise, in an equitable manner, both breadth and depth of excellence in performance.

Under the proposed new scheme, there will be a single application for all tiers of award. We plan to model the suitability of the present scoring system to evaluate its validity and reliability in light of this modification. We will also fully-evaluate the potential effects of any new scoring system in this context.

How would you improve the scoring system?

Focus Group 4 – Equality and Diversity

Equality and diversity are values that concern ACCEA greatly. We may have statutory obligations towards them, but, broader than that, we run a competition that recognises and rewards the value added by consultant doctors and dentists and academic GPs across England and Wales. It should be fair and accessible to all those eligible to apply, heedless of background and characteristic.

Whilst we consider the current scheme to be broadly fair, we recognise that the it falls short on accessibility, with under-representation of female consultants and consultants from Black, Asian and Minority Ethnic backgrounds as a proportion of applicants and so as a proportion of award-holders.

We are keen to ensure the proposed new scheme resolves existing inequities.

Questions:

4.1 To what extent do you think our plans to reform CEAs will promote equality and diversity?

4.2 What more should we be doing?

4.1 Equality and diversity under the existing scheme

As a public sector organisation, the Advisory Committee on Clinical Excellence Awards (ACCEA) has duties under the Equality Act 2010. These are to have regard to the need to:

- eliminate discrimination;
- advance equality; and
- foster good relations between groups.

In particular, we have to fulfil these duties in respect of the following 'protected characteristics':

- Age
- Disability
- Gender Reassignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation

We consider that people sharing their sex, race or age group may be more affected by biases in our system than people sharing other characteristics. While we believe there is no overt bias or discrimination in our processes, we are aware that there may be unconscious biases in ACCEA's own internal processes, associated processes (employer sign-off, ranking and nomination) or more broadly in terms of career opportunities and progression that can form the basis of the evidence an applicant presents. As such, we focus on these three characteristics.

We are, however, receptive to suggestions about how we might better serve other groups (not necessarily defined by the protected characteristics) who may be disadvantaged.

Diversity of the consultant population in England

According to NHS Digital's workforce statistics[1], the consultant population's gender, ethnicity and age profiles are as follows:

	Female	Male	White	BAME[2]	Not stated or unknown
Percent	37.2%	62.8%	56.4%	37.4%	6.2%
Number	19,369	32,761	29,423	19,490	3,217

	Under 25	25 to 34	35 to 44	45 to 54	55 to 64	65 and over
Percent	0.0%	1.9%	34.9%	40.4%	19.7%	3.2%
Number	0	988	18,183	21,041	10,273	1,645

[1] Hospital and Community Health Services (HCHS) workforce statistics: Equality and Diversity in NHS Trusts and CCGs in England, September 2019: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2019

[2] Black, Asian and Minority Ethnic

Success rates

To ensure that our processes are fair and transparent, we analyse the diversity of new award recipients and publish the data in our Annual Report.

- Race

New award success rates as a proportion of applications by ethnicity 2014 – 2019

Year	2014	2015	2016	2017	2018	2019[3]
BAME	13.9%	29.9%	26.1%	25.7%	23.3%	28.2%
White	21.6%	25.9%	26.8%	30.2%	31.8%	34.6%
Gap	-7.7%	4.0%	-0.8%	-4.4%	-8.5%	-6.4%

Consultants from BAME backgrounds, have been significantly less successful than their white counterparts in securing a new national CEA in four of the last six years.

Looking at statistics on ethnicity from our 2018 competition (the most recent year for which we have analysis), consultants from BAME backgrounds constituted 36% of the workforce, but only made up 22% of applications, receiving 16% of the awards. The number of BAME applicants and award recipients was lower than in previous years.

- Sex

New award success rates as a proportion of applications by sex 2014 – 2019

Year	2014	2015	2016	2017	2018	2019[4]
Female	16.5%	26.4%	25.6%	26.7%	30.2%	33.2%
Male	21.7%	26.5%	26.8%	30.0%	31.3%	32.5%
Overall	20.7%	26.5%	26.5%	29.5%	31.0%	32.7%
Gap	-5.2%	-0.1%	-1.2%	-3.5%	-1.1%	0.7%

Looking at statistics on sex, in the 2019 competition, about 37%[5] of the consultant community in the NHS in England at the time of application were female, whereas they constituted only 26.3%[6] of applicants for national CEAs. Women have been consistently under-represented as a proportion of applicants. However, where women do apply, they are broadly as successful as men across multiple years.

- 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

[3] ACCEA provisional statistic
[4] ACCEA provisional statistic
[5] Hospital and Community Health Services (HCHS) workforce statistics: Equality and Diversity in NHS Trusts and CCGs in England, March: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/nhs-workforce-statistics---march-2019-provisional-statistics
[6] ACCEA provisional statistic

previous successful applications. In addition, the current structure of CEAs is such that consultants must progress through the award tiers.

This means that we would expect the average age of award holders to increase with the award level as indicated below:

Average age (at August 2019) of successful 2018 applicants for a new award by award level

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

The below table shows that the highest success rates in our 2018 competition was for applicants between the ages of 46 and 50. The peak success rate at each successive award level is achieved by progressively older age groups.

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.

Current award holders

When we examine the current cohort of award holders, we can see that long term under-representation of female and BAME applicants and lower success rates have led to women and consultants from BAME backgrounds being significantly under-represented at all award levels. This disparity is more evident at higher award levels as the pool of potential applicants becomes progressively less representative.

National CEA holder demographics as at 21 July 2020

	Bronze	%	Silver	%	Gold	%	Plat'm	%	Total	%
Male	860	76.6%	585	83.8%	191	83.4%	79	86.8%	1715	80.1%
Female	263	23.4%	113	16.2%	38	16.6%	12	13.2%	426	19.9%
White	874	77.8%	576	82.5%	188	82.1%	71	78.0%	1709	79.8%
BAME	213	19.0%	112	16.1%	34	14.9%	15	16.5%	374	17.5%
Not stated	36	3.2%	10	1.4%	7	3.1%	5	5.5%	58	2.7%
Total	1123		698		229		91		2141	

Sub-committees

One way in which we have been trying to advance equality and minimise bias is though ensuring that our scoring sub-committees are as diverse as the consultant community they serve. In August 2020, they were composed as follows:

ACCEA sub-committee membership by gender and ethnicity as at 3 August 2020

Region	Male	Female	%F	White	BAME	%BAME	Total
Arm's Length Body	6	10	62.5%	11	5	31.3%	16
Cheshire and Mersey	18	9	33.3%	19	8	29.6%	27
East of England	21	7	25.0%	23	5	17.9%	28
East Midlands	15	8	34.8%	14	9	39.1%	23
London North East	16	5	23.8%	13	8	38.1%	21
London North West	15	6	28.6%	17	4	19.0%	21
London South	8	13	61.9%	16	5	23.8%	21
North East	14	8	36.4%	16	6	27.3%	22
North West	21	7	25.0%	18	10	35.7%	28
South	12	9	42.9%	18	3	14.3%	21
South East	14	8	36.4%	18	4	18.2%	22
South West	17	6	26.1%	19	4	17.4%	23
West Midlands	16	9	36.0%	11	14	56.0%	25
Yorkshire & Humber	16	8	33.3%	12	12	50.0%	24
Wales	19	5	20.8%	19	5	20.8%	24
Total	228	118	34.1%	235	111	32.1%	346

We have made good progress in increasing sub-committee diversity over recent years, but there is more to do, as the above table shows. Few of our sub-committees are both sex- and ethnicity- representative. Overall, they are 3% under-representative of women and 5-11% under-representative of consultants from BAME backgrounds when compared to consultant demographics in England.

4.2 How the proposed new scheme may improve equality and diversity

In designing the proposed new national Clinical Excellence Awards scheme, we want to ensure it employs a fair and transparent process and improves the diversity of applicants and award holders. We also want to address institutional biases that may currently prevent each year's applicants from being representative of the consultant population. We believe that two measures, in particular, will help.

Making CEA application a part of performance discussions

We think that women and minority ethnic groups may be less likely to self-promote and self-nominate. As the current scheme is accessed through self-nomination, this would result in an inherent under-representation amongst applicants and so also award holders. It also means that suitable candidates may miss out through lack of self-confidence or through modesty.

To avoid bias associated with employer (or other) nomination, we believe eligible candidates should continue to apply by self-nomination. However, where appropriate, we think employers and others (such as universities and royal colleges) should provide more active encouragement and support for those eligible clinicians deemed to be high performers.

In particular, in England we wish to see a discussion on suitability for applying for a national CEA to be part of a consultant's end-of-year performance appraisal and job planning discussion, alongside consideration of their potential to receive a local performance payment. Wales' Commitment Awards are already a part of the appraisal process, being applied after 9 years of service, subject to satisfactory performance review.

Alongside this, ACCEA expects employers to ensure applicants from their organisation reflect the diversity of their consultant workforce, with active support for more female consultant applicants as well as those from BAME backgrounds, those working less-than-full-time and other under-represented groups. All processes by which employers decide which consultants will receive support should follow best equality and diversity practice, with all staff involved being appropriately trained. We will expect employers to give a clear undertaking that this is the case.

Reporting and scrutiny

We plan to support this by reporting the outcome of each year's competition, analysed by ethnicity and sex, back to our sub-committees and to employers; and by continuing to include this information in our annual report.

Single tier applications

Under the proposed new scheme, we would eliminate the current system of progression from bronze to silver to gold to platinum. Instead, the strength of the application will determine the level of award.

As mentioned above, applicants from BAME backgrounds and female applicants have been consistently under-represented as a proportion of applicants. This means, for example, that the bronze pool that could apply for a silver award was not

representative of the wider consultant population, with this effect being magnified at the higher award levels.

In removing progression, the potential applicant base would always be almost the entire consultant population, eliminating this inequity.

In addition, there will no longer be a requirement to serve time at each level in order to progress. This means that, although time will be required for the accrual of evidence, younger consultants will have an opportunity to obtain a platinum award sooner than under the current system, if their evidence justifies it.

Other measures

Other measures we are considering that may promote fairness and equality are:

- Making the awards non-pensionable, meaning that retire-and-returnees would no longer automatically forfeit a new style award (existing rules for current awards would still apply during any transition period) and could use evidence spanning their retirement for any subsequent CEA application
- Name-blind applications to minimise conscious and unconscious bias
- Ensuring that the language and terminology we use is accessible and characteristic-neutral
- Paying less-than-full-time consultants (the large proportion of whom are women) the full award value rather than pro-rating its value
- Ensuring that the new application portal is compatible with assistive technologies, helping all those with visual or other impairments who need to use it

To what extent do you think these measures will promote equality and diversity?

What more should we be doing?

Focus Group 5 – Sub-committee structure

ACCEA would not be able to operate without the good work of our fifteen scoring sub-committees, each of which comprises around twenty-four volunteer scorers of three membership types: professional, non-medical professional and employer. These volunteers are a key part of a successful CEA competition

The sub-committee regions were based upon the geography of the deaneries and may no longer be the best means of dividing our work. It is important that the number, geography and constitution of the sub-committees enable a fair competition and reflect the diversity of the communities they represent.

Questions:

5.1 We propose to maintain (largely) regional scoring, but is this the correct approach, given variable sub-committee workloads?

- If so, how should it be structured?
- If not, what is the alternative?
- Is there any merit to scoring a different region, or mixing regional scorer allocations by sub-committees?
- Should we adopt an 'external examiner' model, with one or more assessors from another region sitting on every sub-committee?

5.2 Is the current sub-committee structure of 50% professional, 25% non-medical professional and 25% employer members still appropriate?

5.3 How can we ensure we recruit and maintain sufficient numbers of properly trained scorers with appropriate levels of diversity?

5.1 ACCEA's Sub-Committees

ACCEA in England is supported by: 13 English regional sub-committees; an Arm's Length Body (ALB) sub-committee; a National Reserve sub-committee (NRES) and a Platinum scoring sub-committee, consisting of the regional sub-committees' Chairs and Medical Vice Chairs; and a Platinum sub-committee comprising Main Committee members. The English regions, based on former deaneries are:

- Cheshire and Mersey
- East of England
- East Midlands
- London North East
- London North West
- London South
- North East
- North West
- South
- South East
- South West
- West Midlands
- Yorkshire and Humber

Wales runs its own sub-committee and processes, which ACCEA administer and for which we also provide governance oversight.

Each sub-committee is led by a Chair (a non-medical professional member) and a Medical Vice-Chair (MVC, a professional member), apart from the ALB and Platinum sub-committees, which are chaired by the national Chair. There is also an NRES and Platinum scoring sub-committee, which do not meet.

Each sub-committee member is assigned to a scoring group, scoring either all the bronze new and renewal applications, or all the silver and gold new and renewal applications received from their sub-committee region. Platinum applications are scored by the (national) Platinum scoring sub-committee.

Scorers have at least seven weeks to complete main (non-NRES) scoring. The number of applications to score varies by scoring group, by region and year-to-year. In 2019, the average number was under 40, with a range from 20 to 84. Chairs and MVCs score both groups. Depending on numbers, we estimate that scoring would take between 20 and 30 hours on average.

In our 2021 competition, we expect these numbers to increase, as those who were due to renew in 2020 will be applying, in addition to the 2021 renewals. It is also possible that there will be twice the number of applications for new awards following the suspension of the 2020 competition. To prepare for this anticipated increase in application numbers, we are considering increasing the number of scoring groups, (each thus having fewer scorers) and creating a national pool of scorers that we may draw upon to smooth out variations in sub-committee workload.

Once main scoring is complete, the sub-committees, (except the Platinum scoring sub-committee), meet to discuss the provisionally successful new applications, as identified by the scoring and to discuss applications the national Chair and Medical Director nominate for discussion after their independent review. The aim of this process is to quality-check the scoring. All sub-committee members are free to raise

any issues with any applications that are above the cut-off for success. Unsuccessful applications that fall 'below the cut-off' and renewal applications are not discussed.

Any new applications identified for re-scoring, or which tie at the cut-off, are sent for scoring by the NRES committee.

Following these processes, any applications that remain provisionally successful are recommended to ACCEA's Main Committee and then to Ministers for approval.

Goals/benefits

Our aim is to have a rigorous scoring process, with enough people scoring each application for the outcome to be statistically robust; and for provisionally successful applications to be sufficiently quality checked by our governance reviews. We aim for a minimum of ten scorers per application, but acknowledge that sometimes members fail to score, leaving fewer than ten scorers. We require an absolute minimum of seven scorers per application for validity and in 2019 we were uncomfortably close to this in some sub-committees. As such, we are looking to increase sub-committee membership and flexibility for 2021, given the higher volume of applications expected. As of October 2020, more than fifty new members have been recruited.

As sub-committee members come from the same region as the applicants, they have a better understanding of the significance of the evidence presented than a central national panel would. This regional link also encourages our scorers to take ownership of the scoring process. It is also a convenient way to split up the large workload ACCEA has.

Members are appointed not as representatives of any organisation or clinical specialty, but as individuals who use their background knowledge and experience to assess applications in a fair, transparent and equitable manner.

The significance of this is detailed in the extensive research done by Professor John Campbell: https://bmjopen.bmj.com/content/6/6/e011958.abstract:

> ***Conclusions**: Assessment processes pertaining in the competitive allocation of public funds need to be credible and efficient. The present arrangements for assessing and scoring applications are defensible, depending on the level of reliability judged to be required in the assessment process. Some relatively minor reconfiguration in approaches to scoring might usefully be considered in future rounds of assessment.*

Drawbacks/Disadvantages

There are some disadvantages to the current approach. For example, there is additional work required from the Secretariat to manage conflicts of interest, where professional sub-committee members, (see next section), will often also be applying for their own award, which would be scored by their sub-committee.

There is also an uneven workload across the sub-committees. For example, in 2019 Cheshire and Mersey had 21 new bronze applications to score, whereas London North East had 73.

Platinum applications are also treated differently from bronze, silver and gold applications, with the sub-committee discussing the provisionally successful applications being different from the sub-committee that had scored them.

Possibly the biggest drawback to the current regional approach, is that scorers will inevitably know, or know of, some of applicants and thus be positively or negatively influenced by that knowledge. Whilst we are clear that no advocacy is permitted in the sub-committee meetings, we are mindful of how this might be perceived.

We propose to maintain (largely) regional scoring, but is this the correct approach given variable sub-committee workloads?

- **If so, how should it be structured?**
- **If not, what is the alternative?**
- **Is there any merit to scoring a different region, or mixing regional scorer allocations by sub-committees?**
- **Should we adopt an 'external examiner' model, with one or more assessors from another region sitting on every sub-committee?**

5.2 Sub-committee membership.

ACCEA brings in volunteer scorers to ensure that the right experience and judgement is brought to the assessment of CEA applications. Our sub-committees are made up of three categories of member:

- Professional members (practising consultants) make up 50% of the committee, numbering around 12 members;
- Employer members (from Trusts and Arm's Length Bodies) make up 25%, around 6 members; and
- Non-medical professional members (NMPs) (to give an objective view) make up 25%, around a further 6 members.

Professional members have backgrounds in medicine, dentistry and general practice. Employer members bring their perspective in service and organisational management. NMPs bring their knowledge about healthcare and the workings of the NHS; and represent the patient perspective.

The Platinum scoring sub-committee and the NRES sub-committee are made up of Chairs and Medical Vice Chairs from the regional sub-committees (and so are 50% professional members and 50% NMPs). In this way, our most experienced members score the borderline applications and the applications for the highest value awards.

Is the current sub-committee structure of 50% professional, 25% non-medical professional and 25% employer members still appropriate?

5.3 Recruitment and training

Our target is for each sub-committee to have at least 24 members, to ensure a good representation of the consultant population. When multiplied by 15 sub-committees, this means we have a target cohort of at least 360 members. Recruitment and training of sub-committee members is a significant task for our small secretariat.

Recruitment

Whilst we can identify recently successful award holders to recruit as professional members, we rely on word of mouth and canvassing from sub-committee Chairs and MVCs and from our stakeholders to secure non-medical professional and employer members. The table below shows the total number of members in each region.

The non-medical professional (NMP), professional and employer columns are highlighted in yellow, where we need to boost the number of members for this group. The last column is coloured red, where there is an overall shortage of members of these sub-committees.

ACCEA sub-committees by membership type as at 3 August 2020

	NMP	Profes'l	Employer	Total
Arm's Length Body	6	9	1	16
Cheshire and Mersey	7	14	6	27
East of England	6	17	5	28
East Midlands	7	14	2	23
London North East	4	15	2	21
London North West	4	15	2	21
London South	6	11	4	21
North East	6	11	5	22
North West	7	15	6	28
South	5	13	3	21
South East	5	13	4	22
South West	5	14	4	23
West Midlands	4	16	5	25
Yorkshire & Humber	6	14	4	24
Wales	6	12	6	24
Total				346

Professional members are normally easiest to recruit, as we can approach consultants who have been successful in the most recent competition. They can agree with their managers for their scoring activities to be made a part of their job plans.

NMPs are more difficult to recruit, but once recruited are often amongst our most dedicated scorers. They receive an allowance for their efforts. While they do not have the responsibility of clinical duties, they are often active in other professional spheres.

As the above table shows, employer members are the most difficult to recruit. The employer member need not be a senior official but could be a manager within the medical directorate or human resources teams. However, it can be difficult to identify

people to approach and then for those people to receive permission to take time out from their more regular duties.

As we focus on recruiting to the sub-committees, we are mindful of the need to improve gender and BAME representation. We have made good progress in recent years, but there is more to do. Please see page 23 for more details.

Training

Up to now, we have provided a maximum of two scoring training sessions per year, held face-to-face in a classroom. These are run by our Medical Director and targeted primarily at new recruits. However, the Coronavirus lockdown has led us to consider how we might offer more, distanced, training sessions in future, using the conferencing technology we are now all more familiar with. This may enable us to offer more refresher training to existing members.

We would also like to offer training materials on unconscious bias and protecting information, that can be referred to as needed by our scorers, especially those who do not receive regular refreshers in these subjects from their employers. However, we have not identified anything suitable that we can share.

How can we ensure we recruit and maintain sufficient numbers of properly trained scorers with appropriate levels of diversity?