Consultation on reforming the national Clinical Excellence Awards scheme

UCEA Consultation Response

UCEA

This is the response from the Universities and Colleges Employers Association (UCEA) to the consultation by the Department for Health and Social Care (DHSC), the Welsh Government and the Advisory Committee on Clinical Excellence Awards (ACCEA) on, "Reforming the national Clinical Excellence Awards (NCEAs) scheme". The response is based on views provided by 18 of our member higher education (HE) employers with medical schools.

UCEA represents the views of higher education institutions (HEIs) across the UK in their capacity as employers. UCEA is a membership body funded by subscriptions from 163 HEIs in the UK including 44 HEIs with medical schools, in addition to eight sector associate members. Our purpose is to support our member HE employers in delivering excellent and world-leading higher education and research by representing their interests as employers and facilitating their work in delivering effective employment and workforce strategies. HEIs are independent employers and determine their own employment policies, often in consultation with recognised trade unions; therefore, there are a variety of HR practices in place in the sector.

UCEA supports our member HEIs with medical schools and interprets government and NHS policies that have an impact on the recruitment and employment of clinical academic staff. A clinical academic is usually a practising qualified doctor or dentist who works in an HEI in a teaching and/or research role. Consultant clinical academics can apply for and receive NCEAs and local Clinical Excellence Awards (LCEAs) in recognition of clinical performance at an exceptional level. Senior Academic General Practitioners (SAGPs) are clinical academics specialising in primary care who undertake duties commensurate with consultant clinical academics. Whilst SAGPs are eligible for NCEAs, they do not currently, however, have access to a LCEA scheme.

Summary Response

HEIs broadly support the three overarching objectives of the proposals set out in the consultation namely to broaden access to the NCEA scheme; make the application process simpler and more inclusive and ensure that the scheme rewards and incentivises excellence.

Our members commented that CEAs are an important mechanism for recognising the achievement of clinical academics and encouraging recruitment into this career path and it is critical that the eligibility of clinical academics (including SAGPS and public health physicians) for CEAs is transparent. It is essential that the well-established principle of pay parity between NHS consultants and clinical academics is maintained and they are treated as equivalent to their hospital colleagues regarding eligibility to NCEAs. Our members felt there should be a categorical commitment that clinical academics are automatically included, fairly and consistently, alongside their NHS counterparts for both LCEAs and NCEAs. Our members further commented that it is critical that clinical research is included as a key component in any evaluation criteria for NCEAs.

HEIs highlighted the disadvantage to SAGPs of the proposal to remove the bronze level NCEA. SAGPs do not currently have access to a LCEA scheme, therefore, the earliest level of award they can hope to achieve is the bronze national award. If this is removed, it further

decreases the chance of SAGPs achieving any award. HEIs commented that not only does this seriously disadvantage some individuals (such as women who form a substantial component of the small SAGP cohort nationally) but the lack of access to a local awards scheme means that SAGPs are particularly disadvantaged compared to all other consultant colleagues – limiting career progression in the early years, and making for a substantial barrier if having to apply for a silver level award rather than being able to move through a series of local awards, bronze award and silver award during the course of an academic career. Our members noted that although this problem is widely recognised, an appropriate solution has yet to developed and it is important to raise this issue with a view to ensuring that the problem is addressed as part of the ongoing discussions.

Overall, our members commented that there is sense from the proposals that there will be a significant reduction in the funding for the award scheme and in the status of CEAs and NCEAs. Members felt this was inappropriate as it is vital to be able to identify and recognise the substantial contribution of senior, high-profile and successful medical professionals nationally and the potential to do this appears to be being substantially reduced, with potential adverse consequences on individuals aspiring to major national leadership roles whether in respect of service delivery, education, research or leadership.

Questions from online questionnaire

Question 1: Do you agree or disagree that the number of available CEAs should be increased so that 1% of the eligible clinical population could hold a platinum award; 2% a gold award and 3% a silver award? (please indicate yes or no)

On balance, we are in favour of increasing the number of available CEAs in line with the proposal. Members were concerned, however, that the total funding for the scheme seems to be reducing.

Several of our members felt that removing bronze level awards in order to increase the number of available CEAs was potentially problematic. Our members were concerned that the removal of the bronze award and its effective reallocation to the LCEA scheme would adversely impact SAGPs as this group does not have access to LCEAs. This may impact on their career choice decisions and reduce recruitment to academic positions in primary care – a cohort that is already very small with circa only 150 SAGPs. In addition, HEIs noted that setting silver as the starting level for NCEAs may deter women and people from ethnic minority groups from applying as it may be perceived as too high a level to achieve at NCEA level and it was suggested that it might be preferable to have more bronze level awards and fewer at silver, gold and platinum levels. Our members commented that the removal of bronze levels may also potentially disadvantage clinical academics who are engaged in national and international activities of value to the NHS and UK Life Sciences but with less local immediate value. Whilst these individuals may be able to apply for a silver NCEA, the removal of the bronze level increases the gap between LCEAs and NCEAs and they may not yet be able to apply for an NCEA.

There is a tension between high value awards which are focussed on a smaller number of outstanding individuals, and the desirability of recognising a larger number of individuals with substantially smaller awards than currently; and that the proposed system will favour the latter approach which leaves a significant drop in the level of award for the most outstanding contributors.

Question 2: Wales specific questions

Do you agree with the proposed level in light that there is no local CEA (LCEA) scheme in Wales? (please indicate yes or no)

On balance, we agree with the proposed level.

In Wales we propose to retain the bronze level award scheme because there is no LCEA scheme in place. Do you agree or disagree that this is a good option? (please indicate yes or no)

Yes. The bronze award would still sit above the top level of the Commitment Award scale and the maximum value of the Commitment Award scheme is circa £10,000 less than that of the top of the LCEA levels in England. The situation therefore is different in the two countries.

Question 3: Local performance awards and NCEAs - do you agree or disagree with the proposed value at which the NCEAs will be set at the different levels, of at least: silver - £20,000, gold - £30,000 and platinum - £40,000, in light of local performance awards also being available to NCEA holders from 2022? (please indicate yes or no)

Whilst several HEIs were in favour of the proposals, as the values would be proportionate and in line with the revised local scheme, there were a significant number of our members who disagreed with the proposal as it will inevitably divert a substantial amount of money away from national awards in favour of the locally managed LCEA scheme. Whilst the proposals suggest that individual consultants might hold a national and a local award simultaneously it does not follow that those consultants will be able to access both because those who have an impact nationally or internationally may not be the same as those who have an impact locally. Furthermore, the approach to awarding LCEAs differs between NHS Trusts and there is a risk that local schemes become subject to particular local pressures with the potential to exacerbate inequalities and regional differences.

Of the members who disagreed with the proposal, some commented that re-valuing the awards will result in a significant reduction in their financial value, which could act as a disincentive in choosing a clinical academic career path. It could also result in consultants who previously utilised the NCEA scheme as a means of surrendering private practice to allow them to concentrate on research/quality improvement, no longer being prepared to offer this level of commitment.

In addition, not only are the values of NCEAs set to reduce but they were also decreasing in terms of loss of pensionable contributions.

Our members suggested that further modelling is undertaken on the number and value of NCEAs and LCEAs, particularly when further details of the LCEA and NCEA scheme are available.

Question 4: Changes for domains for assessing NCEA applications - do you agree or disagree with these modified domains? (please indicate yes or no)

Yes. However, it would be important that there is explicit guidance for Trusts that the revised domains are suitable for clinical academics.

The inclusion of a “catch-all” domain for applicants to provide evidence of any other work of nationally or internationally recognised quality could lead to difficulties in scoring consistently

and that clear guidance would be needed in terms of what material might be appropriate in this other domain There is little reference in the modified domains to the value and national impact of clinical research, which is just as important as delivering the clinical service and this may be a disincentive for choosing a clinical academic career. This should be amended so as to avoid creating a disincentive to pursuing clinical research, and a disadvantage to clinical academics. HEIs mentioned the need to include evidence of effective and excellent team working and operating as a role model in the domains and suggested adding inclusivity to the leadership domain.

Question 5: Improving access to the NCEA - Do you agree or disagree with our proposals for improving access to the NCEA competition? (please indicate yes or no)

Yes. There is a clear link between NCEAs, LCEAs and the gender pay gap (GPG) in medicine and whilst it is essential to look for ways to reduce the GPG and significantly improve the representation of black, Asian and minority ethnic groups it was not clear that the proposals go far enough in this regard. HEIs felt that it was essential to use the opportunity presented by reform of the NCEA scheme to ensure greater diversity in those holding awards and the spread of disciplines in which these awards are held. Our members commented that NCEAs should not be a substitute for action on GPGs which should be addressed by separate mechanisms, particularly given that the revised allocation in the proposals will result in NCEAs being available to circa 6% of eligible consultants in England.

Do you have suggestions on how we can improve access to the scheme for women and those with protected characteristics?

HEIs highlighted that it is important that the nominations and awards processes are monitored in terms of the percentages of women and those with protected characteristics who apply and who are successful. Employers and specialist societies should provide data on how their nominations reflect the population of their consultants and be asked to address any significant deviations in the nominations from the characteristics of the populations they represent.

It would be useful to provide support for underrepresented groups to apply including mentoring, examples of good applications and exemplar case studies will help to ensure equal access to awards. In addition, given the high level of team working in the NHS, encouraging applicants to demonstrate cross team working will be seen as a demonstration of a positive and collaborative leadership contribution,

HEIs noted that CEAs contribute to a significant proportion of GPGs relating to bonuses for clinical academic staff. Some of our members pointed out that unfortunately the fundamental issue is that the current demographic of clinical academics is largely male dominated. Whilst HEIs have been undertaking much work to change this, the prolonged training period for clinical academics means that it may be many years before the proportion of women clinical academics increases. The consequence of this is that the approach whereby awards are made to a set percentage of the consultant population, the majority of whom are men, will continue to drive the GPG for clinical academics.

Our members made the following further suggestions for improving access to the scheme for women and those with protected characteristics:

- Provide regular updates on the equality, diversion and inclusion activities being undertaken to promote access to the scheme for women and those with protected characteristics and a comprehensive analysis of successful award applications.

- Have ambassadors in the NHS Trusts to talk to those individuals who HEIs consider should specifically put their name forward.
- Run NCEA 'clinics' or 'sessions' within HEIs to help clinical academics and SAGPs apply for the awards and complete the necessary paperwork.
- Have CEA Champions in the relevant Schools/Departments in HEIs.
- Have a buddy system or mentoring approach / case studies from individuals within these groups that have been previously successful so that there are exemplar cases available to review and inspire.
- Offer targeted coaching workshops and mentoring opportunities for staff who are under-represented in the process.
- Acknowledge that there is a tendency for women applicants to present their achievements as a result of collaboration and teamwork and recognise that approach explicitly as a positive trait in the criteria / guidance.
- Ensure guidance is in place for committees/panels to ensure they take account of unconscious (and conscious) bias and can adjust expectations of output to account for different full time equivalent (FTE) to ensure LTFT work is not undervalued.
- Ensure there are appropriately representative panels/committees that reflect the demographic targets that employers are aspiring to.
- Women often take time out of training for family reasons, or work part time during their training, and will find they are much later in their career before they are eligible to apply for a CEA. Explore a mechanism to allow additional weighting and recognition of achievements for some groups earlier in their consultant careers.
- Better childcare facilities for all NHS staff.
- Anonymised application forms e.g., omit name, ethnicity and gender.
- Consider the language used within the NCEA application process and remove gendered or other biased language.

How far do you agree that those working LTFT should be in receipt of the full award value as opposed to the current pro-rated award payment?

There were differing views among our member HEIs who responded on this point although a higher proportion agreeing that those working LTFT should be in receipt of the full award value. HEIs commented that if all applications are assessed in the same way regardless of FTE, then payment should also be regardless of FTE. HEIs did express reservations about the proposal, however, and suggested that different approaches to address the underlying concerns are explored as it is not a case of "one size fits all", for example, whether to assess submissions from those working LTFT against full time staff but award at the full value, or take LTFT into account when assessing the submission.

Our members commented that inequality may arise where individuals working LTFT are assessed against the same standards as a full-time member of staff. Arguably the unfairness is not considering FTE in the assessment and the assessment process is therefore key to this. Members felt that assessment of individuals working LTFT should be proportionate to their working time, with a focus on the totality of an individual's contributions to the main domains and to the NHS in terms of quality, not quantity. Members suggested that specific guidance for panels in marking assessments for LTFT would be helpful and that it may be useful to test whether women working LTFT see this as a positive move with organisations such as the Medical Women's Federation. It may also be useful to consider auditing employers in respect of their support for part-time applicants.

HEIs highlighted an important assumption that a clinical academic who works full time, but only spends a proportion of their time undertaking direct clinical activity would be considered full time for the purposes of a CEA application and award.

Question 6: Maintaining excellence during the period covered by a CEA - do you agree or disagree that this is an appropriate way of incentivising the maintaining of excellence during the period covered by a CEA? (please indicate yes or no)

Yes. In general, individuals who obtain CEAs are highly conscientious and motivated and they continue to work above and beyond their contractual requirements during the period of their reward.

What proposals do you have to ensure CEA holders maintain clinical excellence throughout the time they hold the award?

The following proposals should be considered:

- Award holders should submit an annual report demonstrating their continued clinical excellence over the previous twelve months and be required to evidence their continued excellence and progress against the plan submitted in their successful application for a CEA. HEIs acknowledged individuals' future plans may change but advocated that CEAs should consider award holders' future work and its impact for the duration of the award, rather than focussing solely on the award-holder's past work.
- Manage the maintenance of clinical excellence tightly through good line management and joint NHS clinical appraisal and job planning and integrate into HEIs' annual academic planning / appraisal processes to ensure that there is alignment between future plans and the CEA application process.
- Have open, supportive two-way discussions as part of ongoing performance development reviews. In most cases the reviewer will be the line manager but, in some cases, HEIs/Trusts should consider using a clinical expert to support the review.
- The forward plan / trajectory should be signed off by Trust and HEI (if a clinical academic) and should be helpful to the individual from a career development perspective. Appropriate wording is needed to prevent any gender bias, for example if an individual were due to commence maternity leave it would be important that this is not perceived as a limit.
- Reiterate the importance of leadership and team development, plus developing others and supporting equity and inclusion aims.

Despite the above points, it is important to avoid adding a further layer of bureaucracy to an already stretched system.

Question 7: An end to the renewals process - do you agree or disagree that the 5-year award period should be retained, but ending the renewals process for awards, with clinicians applying for a new award at the point of expiry? (please indicate yes or no)

The majority of HEIs agreed overall with the proposal. Our members did have some reservations that removing the renewals process and thereby considering applications from a no award baseline may result in the system becoming more burdensome and difficult to manage for ACCEA. Some of our members also expressed concerns that retaining the five-year award period may not help to address some of the inequities of the scheme/ accessibility to the scheme. Reducing the award period slightly might help in this respect. A

counter argument to this was that in reducing the term, individuals are required to apply more frequently, which could disincentivise applications from women and other underrepresented groups.

the argument put forward for ending the renewal process is to simplify the process. However, it is not clear that ending the renewals process would deliver this aim given that the same forms are completed for renewal and new awards.

Question 8: The pensionable status of NCEAs - Do you agree or disagree that NCEAs should be non-pensionable? (please indicate yes or no)

On balance, we agree that NCEAs should be non-pensionable. However, there is a serious sense that the NCEA scheme is being devalued and substantially reduced through the removal of the bronze level, NCEAs being non-pensionable and a substantial reduction in the overall values of national awards. Our members stated that any action that reduced the likely pension or value of the awards that currently exist would not be welcome.

Some HEIs highlighted that rather than the pensionable status of awards it is more important whether more rewards become available for clinical academics, clinical scientists, and underrepresented groups. HEIs also recognised that making CEAs non-consolidated and non-pensionable would increase the number of new CEAs, however, there were reservations it may adversely affect the ability to recruit clinical academics in the future given that private work would be significantly financially advantageous rather than developing a career in clinical academia.

Our members evidenced that increasingly, different generations have distinctive views and expectations from a benefits package. The non-pensionable nature of the new awards would align with the younger consultant generation who may be less focused on investing in pensions and the move could support greater intergenerational fairness. On the other hand, our members recognised that making CEAs non-pensionable may affect consultants at the early stage of their careers which may disproportionately affect certain groups. Some of our members identified that clinical academics close to retirement age may feel that the move to non-pensionable NCEAs is particularly detrimental and could result in an increase in retirement for this group which could pose a risk to member HEIs whose clinical academic demographic is weighted towards those nearing retirement age.

It would be necessary to undertake an equality impact assessment and further modelling at a national level, on the impact of moving to a non-pensionable scheme on different age groups and for both England and Wales given that the two countries have different local award schemes.

Question 9: The role and value of rankings and citations in the award process - do you support the changes proposed for the role of employers? (please indicate yes or no)

On balance, our members support the changes proposed for the role of employers and welcomed the opportunity to be on employer panels and to validate data. The proposals to remove the ranking of senior clinicians by employers and for employers to provide a statement of their processes to ensure equality, diversity and balanced representation from eligible senior clinicians are particularly helpful. The role and value of scoring, ranking and citations is subjective and whilst some of our members have undertaken considerable work to reduce the unconscious (and conscious) bias in the process, it remains a challenge that

the scoring of panels can be affected depending on who applies and the panel's knowledge of the applicants. Our members noted that the short timescales involved in the application process can cause some logistical issues, which in turn make it harder to establish a balanced panel, therefore a longer lead in time, with transparent timescales communicated in advance would be of considerable help.

It may be necessary for ACCEA to state that in some very limited circumstances they seek a third citation if necessary

Do you have any other comments on the role that employers should take in a new national award process?

HEIs offered a range of comments and suggestions on the role that employers should take in a new national award process including:

- The NHS and HEIs should provide citations for clinical academics – as employers they have an overview of an individual's work and are best placed to comment.
- Ensure that the applications of clinical academic staff are signed off jointly by both the substantive and honorary employers.
- As an employer, HEIs should expect to discuss the NCEA scheme with eligible consultants at least annually and to mentor and support applicants.
- Build employer validation of the case being made into the process to ensure that the information submitted is accurate.
- Impose sanctions on employers who consistently fail to reflect the characteristics of their clinical population when making nominations. In parallel each employer should be asked to identify the current GPG and what steps they are taking to address it.
- In the case of SAGPs, NHS England acts in an honorary "employer" status – it is important that a suitable mechanism is in place for NHS England to provide support to SAGPs applying for a NCEA. NHS England should also act urgently to develop a local CEA scheme for SAGPs

Do you agree or disagree with the changes proposed for identifying who should be accredited NNB or SS and reducing potential over-representation of specialities and sub-specialties? (please indicate yes or no)

Yes.

What criteria should determine whether an NNB or SS should be accredited?

Of our members who commented, one felt that neither should be accredited whilst another felt that only employers and established discipline-specific representative societies should be accredited.

Question 10: Any further comments on future arrangements for the NCEA scheme - do you have any additional proposals or further comments on future arrangements for the NCEA scheme?

Our members offered a range of comments and proposals on future arrangements for the NCEA scheme.

Funding

- The consultation does not currently confirm that NCEAs will continue to be funded by the NHS for clinical academic consultants and this should be stated explicitly.

Access to scheme and GPG

- With the removal of the bronze award, HEIs had concerns that the gap between local and national awards may seem overwhelming for some who are already hesitant about applying for an award. Focused local mentorship and guidance may help to overcome this to some degree, but some clear guidance, together with the transparent criteria and scoring system would facilitate local support activities.
- A fundamental issue remains that women often enter the consultant grade later in life than men due to having taken career breaks or worked LTFT. The current 19-point consultant pay scale, together with CEA Scheme means that women cannot catch up with male colleagues. Members suggested that these NCEA proposals should be considered in conjunction with the development of a new consultant pay scale to allow a holistic consideration of the impact of both on women and other underrepresented groups and an EIA undertaken on the impact of both.
- Closely monitor and report the impact of the proposed changes in terms of the characteristics of those in receipt of these awards and publish data on the characteristics of those holding awards on an annual basis.
- Ensure that there is a suitable mechanism in place for NHS England to provide support to SAGPs applying for NCEAs.

Level of awards

- In light of concerns about the difference in the level of the new awards, HEIs suggested there should be a transition period/payment protection for those renewing at silver, gold and platinum levels.
- Clarify/confirm whether there will be any financial recognition or priority consideration for local awards for individuals who lose a national award.
- Clarify whether there will be any consideration of a transition period/protected payment to ease the impact on pensions for those nearer retirement.

NCEA and LCEAs

- The proposal that consultants can hold both local and national awards is suggested to off-set the impact of the reduced financial value of new national awards. Members commented on the practicality of applying for both local and national awards at the same time as it will add to the workload of clinicians who will have to submit applications to two processes.
- Clarify whether the same evidence can be used for local and national CEA submissions as there is likely to be an overlap many cases.
- Clarify to what extent the level of an individual's existing local or national CEA award will be considered when making decisions about new national or local awards.
- Explore whether there is any scope to improve the scheme access for those moving organisations or with a portfolio of employers. This can be a disincentive currently, as the employer may not recognise previous contributions.