Royal College of Anaesthetists

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By email to:
Dr Stuart Dollow
Chair, Advisory Committee on Clinical Excellence Awards
Professor Kevin Davies
ACCEA Medical Director

Dear Dr Dollow and Professor Davies,

Anaesthesia, Intensive Care Medicine (ICM) and National Clinical Excellence Awards (NCEAs)

I write to respond on behalf of the Royal College of Anaesthetists (RCoA) to the consultation on reforming the NCEA scheme. We are encouraging our 23,000 members to respond online, but we think it important that you receive and consider the agreed response of the leadership of the third largest Medical Royal College by UK membership. The latest NHS workforce data confirm that, with 7,581 consultants[1], anaesthesia (including most ICM doctors) is the third largest medical specialty after medicine (12,508) and surgery (8,699).

Analysis of the larger medical specialties (those with >1,000 consultants) reveals marked disparities between specialties in terms of the numbers of NCEAs held, as recorded in the latest ACCEA Nominal Roll: anaesthetists, who make up 15% of the consultant workforce, have only 6% of the CEAs.

Specialty	**Proportion of Workforce**	**Proportion of NCEAs**	**Equity Ratio**[2]
Pathology	5%	8%	1.43
Medicine	24%	34%	1.40
Paediatrics	7%	9%	1.24
Ophthalmology	3%	3%	1.17
Surgery	17%	17%	1.01
Obstetrics & Gynaecology	5%	3%	0.59
Psychiatry	9%	5%	0.58
Radiology	7%	4%	0.56
Anaesthesia/ICU	15%	6%	0.39
Emergency Medicine	4%	1%	0.28

It is worthy of note that two of the specialties that came under the greatest pressure during the COVID-19 pandemic (Anaesthesia/ICU and Emergency Medicine) have the fewest CEAs by this analysis.

[1] Measured as Full Time Equivalents (FTE).
[2] A ranked calculation of the proportion of CEAs (third column) divided by the proportion of the workforce (second column), using percentage values to the second decimal point – these values are rounded to the nearest per cent in the first and second columns.

Number and level of NCEAs
One of the proposals is that Bronze awards be dropped, leaving only Silver, Gold and Platinum awards. This will disadvantage those medical specialties that have larger proportions of Bronze Awards. At 60%, Anaesthesia/ICM has the largest proportion of Bronze Awards of all specialties. We believe that Bronze NCEAs should be retained.

Broadening access to the NCEAs
The ACCEA monitors only two protected characteristics in applicants for NCEAs: gender and ethnicity. The proposed reforms do not signal a change in this approach. We strongly believe that all protected characteristics should be monitored, and that the comparison made should not only be that between the diversity of all NCEA applicants and successful applicants but also between the diversity of the whole eligible consultant body in the NHS and that of NCEA applicants. Medical specialty and diversity are linked, with specialties such as anaesthesia attracting large proportions of female and ethnically diverse doctors. The ACCEA process must have a broader understanding of how diversity and NCEAs are linked.

Professor Jane Dacre's recent report into gender pay gaps in medicine recommended that "the pay and career penalty for those doctors working LTFT (less than full time) needs to be eliminated". We believe that the existing and proposed NCEA processes sustain the pay penalty for consultants working LTFT. In the current NCEA round, of the 31 applicants seeking support from the Academy of Medical Royal Colleges for Platinum awards, 29 were male. Gender bias is built into the current and proposed processes. In both, there are five scorable domains in the application form. For an applicant to score sufficiently highly to get an award, they must attract scores that represent work that is "over and above contract terms" in at least four of the domains, something that is much more difficult for LTFT consultants to achieve than full time workers. The current proposal that LTFT applicants, **if** they are successful, will be paid the same amount for awards as the full-time workers (they are currently paid *pro rata* according to their contracts) is not sufficient to eliminate the pay penalties created by the system. We believe that there are much better ways to bridge the gender pay gap than that proposed, i.e. by reducing the number of scorable domains for LTFT consultants or by increasing the scores for the domains by a factor based on the applicant's contracted hours of work.

Changes to domains
We oppose the proposed loss of the one domain that focusses solely on the delivery of a high-quality service by the merging of the existing first two domains. This change risks taking the scheme further away from what it was originally intended to be, i.e. a system that rewards **clinical excellence**. We support the inclusion of a flexible domain as proposed but suggest that this be added as an additional domain.

Maintaining excellence during the period covered by a CEA
We do not support the proposal that applicants provide an outline covering the period for which the CEA would be paid. If not monitored, this would prove a pointless and time-consuming exercise, and might produce unfounded guilt in those who suffer life events that markedly changed their projected plans. Further, we argue that the NCEAs represent a reward for things that applicants have already achieved. Making them dependent on the delivery of projected programmes would make them resemble research grants more than rewards for genuine clinical excellence.

Brief responses to other questions in the consultation

Ending the renewals process
- We support this proposal.

Withdrawing the pensionable status of awards
- We support this proposal.

The role and value of ranking and citations in the award process
- We support the requirement that employers ensure a balanced representation of applicants from their eligible population of senior clinicians but suggest that this balance should reflect both protected characteristics and clinical specialty.
- We support the review of national nominating bodies (NNBs) and specialist societies (SSs) to ensure that no specialty or subspecialty is multiply represented by different bodies, although we are concerned about how the ACCEA plans to assess whether NNBs and SSs are of "national standing and influence".
- We support the proposal to limit third-party citations to a maximum of two.

Other comments

Although not included in the consultation, we would like to register our opposition to the current guidance that National Nominating Bodies such as the RCoA can only submit a number of Gold award nominations that does not exceed 3.5% of those with Silver awards (with a minimum of two) and a number of Silver award nominations that does not exceed 3.5% of those with Bronze. Based on the latest ACCEA Nominal Roll data, this means that, in the current round, although medicine is only one and a half times as large a specialty as anaesthesia and ICM, more than four times as many applicants from medical specialties can be nominated for Silver and Gold awards than those from anaesthesia and ICM. We think that these formulae perpetuate specialty inequity in the NCEA system, and that they should be replaced with formulae that allow medical specialties with lower numbers of NCEAs to nominate more applicants.

The current NCEA scheme rewards only consultants. In the recent COVID-19 pandemic surges, we are aware of many non-consultant, non-training grade doctors who worked incredibly hard under very difficult circumstances, often putting themselves at considerable personal risk to treat the sickest patients in the NHS. We are proud that many of these were SAS doctors working in anaesthesia and ICM. We think that the NCEA scheme should be extended to include these doctors and propose that future rounds allow members of the new Specialist Grade to apply for NCEAs.

More radical change is needed than that proposed

As a Medical Royal College, we would like to see the NCEA scheme continue to exist. However, we are aware of widely held views that the system should be scrapped. We strongly believe that a far more radical reform of the scheme than that proposed is urgently needed if the scheme is to achieve the equity of access and reward for our increasingly diverse consultant workforce that it should, can and must do if it is to survive.

Yours sincerely,

Professor William HARROP-GRIFFITHS MA MB BS FRCA FCAI (Hon)
Vice President, RCoA