

Guidelines for ACCEA 2011 Round

Context:

The 'Next Stage Review' (Darzi report) identified areas where the ACCEA process could be used to add incentives to clinicians to become involved in 'leadership' roles and to reward those that did. David Nicholson's letter to ACCEA in 2009 suggested ways in which ACCEA could recognise such activity. Some of those suggestions were beyond an acceptable limit for clinicians and it is reassuring that ACCEA did not incorporate all of the suggestions into their 2010 guidance. This does not necessarily mean they will not use them in later years.

There are real opportunities for us in this guidance and it is important to seize this rather than bemoaning some of the other aspects. The following is an overview followed by a domain by domain review of its impact and some suggestions to consider in crafting individual forms.

General points:

The guidance to assessors for the 2011 round is not yet released. The following detail of how scoring across England and Wales was managed in 2010 is therefore interpretive rather than definitive.

BUT:

The flavour of the guidance is strongly biased towards personal contributions and the use of evidence-based practice. Whilst outcome measures and 'Indicators of Quality Improvement' are more difficult for anaesthesia to match these are more than balanced by the changes in emphasis in the other domains, especially domain 4 (research and innovation).

The catch phrase used throughout "My contribution to this / these outcomes was –" is completely pervasive and clearly should be used or paraphrased in all domains.

The scoring for the domains remains as last year:

- Excellent (10) – outstanding and sustained contribution
- Over and above (6) – Some excellent contributions, all over and above
- Meets Contractual requirements (2) – some activity, but mostly paid for
- No assessable commitment (0) – should not have been submitted

Personal statement: this is not scored but is your summary of what you think are your 4 greatest achievements since your last award.

The scoring panel uses this information as a map to the domains, and expect to see the content clearly identified as they score the form. There is no place for acronyms, abbreviations or spelling mistakes in this (or any other) sections of the form.

If this is your first award (bronze) use the phrase 'In my last 5 years of practice I have –' and if for an advanced award / renewal 'since my last award I have. Any other information has to be vital for it to be included here.

Remember: it is what you have done not who (what) you are that counts.

Job Plan: This should be used to clearly identify what is paid for and what is clearly 'over and above'.

The more PAs above 10 the harder this becomes as activity above a paid 4 hours / week needs to be explicitly identified and quantified. The lay members of the panels understand that a 15PA contract expects a 60hour delivery. Not many of us do that much more.

Domain specific comments:

Domain 1 – delivering a high quality service:

The phrase 'it would not be a disadvantage if evidence is less available in your speciality' cannot be seen as positive, but we wrote to ACCEA to ask that they make this more balanced in their 'Guidance to Assessors'.

There are four key areas although not all need to be outstanding

- Safety
- Measurable clinically effective outcomes
- A good patient experience
- Areas where opportunities for improvement are sought and implemented

We have many safety initiatives and these may be used where we do not have outcome data such as that from ICNARC. Documented adherence to AAGBI / RCoA / NICE or Specialist Society guidelines with improved patient safety is one alternative. Teams, both surgical and medical, often have outcome data and where we have a permanent role we can identify what our individual contribution is, where there is a 'rolling commitment' bringing wider clinical expertise and a greater multi-disciplinary insight can be considered.

Patient satisfaction surveys are very powerful if they have covered an area of practice, obstetric or pain services for instance.

The leadership of a hospital records, transfusion or infection control committee all demonstrate good use of NHS resources and often have opportunities for improvement.

One high profile example at present would be leadership of an acute pain team or the provision of hospital wide training in acute pain management. The development of guidelines that are used by other units may indicate a regional or national standard setting role.

Domain 2 – developing a high quality service

This requires evidence that you have significantly improved clinical effectiveness (quality, safety and cost effectiveness) of your local services or related services across the NHS. The evidence should be (ideally) measurable and your personal contribution. Again this is usually a team event, but personal contributions should be identified where possible.

There is an expectation that personal contributions to National audit projects and Confidential Enquiries will be included. The use of evidence-based practice to improve service delivery, either by making it more efficient, more patient centred, safer and / or more cost effective should be included where present. If there is enough space on the form, add the most appropriate reference as well here.

Patient consultation and responsiveness are valuable markers for excellence in the NHS. Where service changes have included direct patient involvement and improved the quality of the service these should be included.

Higher activity in developing national / international standards, major service review or producing national policies should be a feature of excellent (10) applications.

Domain 3 – leadership and managing a high quality service

Provide evidence of how you have made a substantial personal contribution to leading and managing a local service, or national / international health policy development.

This is one of the major areas of change and will now reward those involved in difficult local and national issues.

Evidence of leadership locally: for patients or where changes have been led and implemented to the benefit of the NHS, its staff and patients. Delivery of support and guidance for consultant mentoring and coaching or appraisal are important.

Involvement in major service reviews and public consultations where complex issues need clear explanations. For us this is usually around ICM, maternity and paediatric service changes and has a clear political aura surrounding it.

Improving all members of the NHS and supporting both clinical and non-clinical staff in progressing to senior management roles is more problematic with the implication of rewarding further medical deprofessionalisation.

The higher scoring elements of leadership – high office (in Spec. Societies, national / international bodies) requires delivery rather than occupancy. Clinical governance is now recognised as a very high value activity (at medical director level). This may also be demonstrated by setting professional standards and guidance that are applicable across the NHS.

Domain 4 – research and innovation

Outline your contribution to research or to the evidence/ evaluative base for quality or service innovation, including the translation of evidence into practice.

This is another major change with the shift of emphasis into evidence based research and translation into practice.

Examples include: new techniques or **service** models you have developed and which have been adopted by others. Including how you have used ‘improvement methodologies in order to get things right’.

The actual or potential impact that your research, which can be laboratory based or **innovative development of health service practice or policy or on the development of health policy**, on the health of patients and the public.

Personal grants, major publication in peer reviewed journals, editorships are still present and **we have no information to suggest that they being altered in the supplemental forms for this domain.**

Domain 5 – teaching and training

“for some applicants, teaching and training will form a major part of their contribution to the NHS, over and above contractual obligations”

The importance of using numbers to quantify the scale of anaesthetic education cannot be overemphasised.

The scope of teaching, from medical student, through doctors in training to established specialists, should be included.

Involvement in course development and delivery, in new ways of teaching and assessment and in writing course materials (such as the e-learning project) are important.

National activity delivered by regional advisors, involvement in the national assessment process by examining for the RCoA, delivering national / international lectures and contributing to the development of other healthcare professions.

Activity for regulators or other educational institutions where personal activity can be demonstrated is also of value.

Evidence of a personal commitment to self-education, through higher degrees or membership of educational professional bodies is also recognised.

Summary:

There are changes that will require a review of completed forms to ensure the best chance of recognition by the ACCEA panels of your personal achievements. Please

take the time to read the full document and change any emphasis necessary to meet these 'mid-term' alterations.

AAT