Department of Health & Social Care

ACCIA
Advisory Committee on Clinical Impact Awards

National Clinical Impact Awards – Example Leadership Domains

Advisory Committee for Clinical Impact Awards 2023

ACCIA 2023

Some examples of Domain 2 (Leadership)

First example – role and job plan:

- *Application 1* – an NHS surgeon working in a busy regional hospital with an 11PA job plan: 9 DCC and 2SPA; no academic sessions in the job plan; no additional programmed activities
- Please read and decide how you think assessors would score the application
- What are the strong points? Any areas that could be improved?

Excerpts from a Domain 2 (Leadership)

Since my Gold award in 20XX, I have worked hard to improve the quality, cost effectiveness & safety of specialised colorectal services. I make these contributions via senior clinical leadership/management roles at NHS England, NCEPOD & Associations of Surgeons & Coloproctology of Great Britain & Ireland (ASGBI/ACPGBI).

1. I have been a member of the NHS England specialised colorectal services clinical reference group (CRG) since 20XX. I was appointed by NHS England as national clinical lead for intestinal failure in February 20XX. I developed the service specification & peer review tool & analysed & validated responses from candidate trusts. I am providing clinical leadership for national service procurement.

2. I became deputy chair of the CRG in 20XX. I am responsible for ensuring equity of access & development of national quality indicators & CQUINs for these specialised services.

3. I am member of the NHS England cross-systems sepsis board - we are developing the NHS strategy for diagnosis & management of sepsis. We published our national "sepsis action plan" in 20XX. – see publications.

4. I advised NCEPOD in its national sepsis audit (20XX-20XX).

5. I co-chaired the ASGBI/ACPGBI working group on colorectal anastomotic leakage, the most important cause of sepsis after bowel surgery. I co-wrote & published the national guidance in 20XX (publication XXXX)

I have played a major role in disseminating my expertise in intestinal failure more widely. Specifically: We run national "intestinal failure masterclasses" to develop teams from other centres in England. Since 20XX I established & developed an MDT specifically for our autologous GI reconstruction service (see below), including dedicated support from a clinical psychologist & anaesthetist. I trained a consultant colleague to help me undertake these procedures, which the NHS commissions only in our unit.

I advised the NICE interventional procedures committee & helped them to produce guidance. I secured funding from the CCGs and we undertook the first two procedures in the UK last year (20XX). We are currently the only centre in the UK offering this service.

My multidisciplinary team continues to lead the world in intestinal reconstructive surgery because of a continued focus on quality improvement. NHS England audited our programme in 20XX & 20XX & said it was "outstanding", noting a 0% 90 day mortality in 123 consecutive high-risk surgical procedures over the previous 3 years - the best results ever produced in the world.

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ASSESSOR: A lot of committee work, but outputs in terms of guidelines and products for patients are defined; every component dated; abbreviations are explained; high quality team-based clinical work developed locally, now nationally and internationally recognised. Clear what has been done since last award. Numbered layout and clear narrative make it easy to read. SCORE = 10

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Some examples of Domain 2s

Second example – role and job plan:

- *Application 2* – an NHS Acute Medicine Consultant in a large teaching hospital with an 13PA job plan: 7 DCC (AMU work); 2 SPA (CPD/audit); 1 PA Medical School teaching lead; 1 PA AMU lead clinician; 2 APA for Research and LCRN speciality lead
- Please read and decide how you think assessors would score the application
- What are the strong points? Any areas that could be improved?

Excerpt from another Domain 2

I am an excellent communicator and manager. During the COVID pandemic I ran a series of in-house Trust fora to explain the need for new rotas to be implemented. I adopted a similar approach when first implementing the 4A-Costs initiative, and plan to do so in our partner Trust. I adopt the same approach with my teaching and training. In my role as Clinical Lead I chair the Audit, Review and Quality committee on a monthly basis, with bi-monthly regional meetings, sharing the chairmanship with my opposite number from St XXXX's. This enables sharing of good practice. We invite both junior staff, rotas permitting, and selected medical students on the unit to attend. These meetings have been virtual during the course of the pandemic.

Another key initiative I have led is the ARC-supported is ARS-P – the Acute Risk Stratification Project. We are one of 4 pilot sites in the region for this exciting project. In addition to the 4A-Costs app-based questionnaire, PAs perform for selected patients a clinical context-dependent series of bed-side assessments and questions to allow relevant acuity scores to be applied (eg HASBLED, Wells score, CURB, SLEDAI, NEWS/MEWS, CPAI etc) and a weighted composite 'sickness' score is allocated. It is being evaluated whether this score will predict death, or deterioration, and the likely LOS. I am the local PI for this exciting project and in my management role I am actively recruiting patients and colleagues. We hope the study will lead to AHSN adoption, and a possible RFpB grant. Such a risk prediction model would have tremendous utility if rolled out nationally (estimated cost savings in England alone – 29.3 million/annum).

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ASSESSOR: Entirely LOCAL work; NO DATES; TMA; reference to same research project in 3 other domains; a lot of 'jam tomorrow'; 13PA

SCORE = 0 (2 at most)