CONSULTATION ON NORTHERN IRELAND CLINICAL EXCELLENCE AWARDS SCHEME

Background

1. A new clinical excellence awards scheme was introduced in Northern Ireland in 2005. The new scheme combined discretionary points and distinction awards into a single graduated scheme. There is a single set of assessment criteria with standard forms for all levels of award. Lower awards (steps 1-9) are decided by employers; and higher awards (steps 10-12) are decided by the Northern Ireland Clinical Excellence Awards Committee (NICEAC). Lower awards range in value from £2,850 (step 1) to £34,200 (step 9). Higher awards range in value from £44,965 (step 10) to £73,068 (step 12).

2. The rationale of the new scheme as set out in the Guide to the Scheme "is to ensure recognition of exceptional personal contributions made by individual consultants who show a commitment to achieving the delivery of high quality care to patients and to the continuous improvement of the HSC".

3. NICEAC has two roles under the new scheme: to make recommendations to the Department on which consultants should receive higher awards; and to quality assure the outworkings of the lower awards process.

4. The new scheme is similar to the clinical excellence awards scheme introduced in England, although there are some differences. In Northern Ireland self nomination is the only method of nomination for an award. There are also different rules relating to eligibility. In Northern Ireland consultants must have completed three years as a consultant to be eligible for a lower award (England – one year); and in Northern Ireland consultants must have achieved four lower awards before being eligible for a higher award (England – none).

5. The new awards scheme was subject to review after three years. We are now in the middle of the third year and it is important that changes, if any, are made in time for the start of the next awards round (2008-2009).

6. The new scheme was introduced in Northern Ireland on condition that measures were put in place in order to contain costs. These measures included: for lower awards the national formula (0.35 awards per eligible consultant) should no longer be applied in order to halt the growth of the scheme; and for higher awards the "new" award element should not be included in order to ensure there was no increase in costs apart from the annual uplift in values of awards.

Lower Awards

7. Under the old discretionary point scheme employers awarded points according to a nationally agreed formula – a minimum of 0.35 points per eligible consultant. Consultants were eligible when they had reached the maximum point of the old consultant contract scale. There was potential under the new scheme for costs to increase. Under the new scheme a consultant is eligible after 3 years, thus increasing the pool of eligible consultants and the number of potential awards under the formula. For example, in the last year of the old scheme (2004-2005) Trusts reported that 456 consultants were eligible to apply for discretionary points and awarded a total of 173 points (exceeding the minimum number required under the 0.35 formula). In the first year of the new scheme it is estimated that around 750 consultants would have been eligible to apply for lower clinical excellence awards (those consultants who had completed three years, and excluding consultants already in receipt of a higher award). This would have generated 262 points according to the formula. In 2006-2007 the increased eligibility pool would have resulted in around 290 lower awards. In addition to a wider eligibility pool, there was also potential for costs to increase due to some increase in the values of awards.

8. In the guidance on the new scheme employers were advised as follows "the formula for calculating the minimum number of points should not be applied. The Department's recommendation is that points should be recycled as consultants retire or leave. Trusts have discretion but will have to meet any additional costs out of its existing budget..".

Higher Awards

9. There was potential for the cost of higher awards to increase as the new awards were of a higher value - the value of a new step 10 award was about £15k higher than an old B distinction award. The number of higher awards for allocation each year was based on retirements/deaths of existing higher award holders. In addition, some "new" awards were allocated based on the growth in the consultant population.

10. Under the new scheme no "new" higher awards were to be allocated. Higher awards were to be allocated solely based on the redistribution of financial resources freed up as a result of retirements/deaths of existing award holders. It was recognised that there would be an overall reduction in the number of higher awards available for allocation given the higher values under the new scheme.

Impact of the New Scheme

Lower Awards

11. In the first year of the new scheme (2005-2006) 71 local awards were made with 9 trusts not making any awards, citing insufficient funds. In the second year (2006-2007) there was some improvement with 110 awards being made (5 trusts did not make any local awards). Overall there has been a significant reduction in the number of new lower awards allocated under the new scheme (173 were allocated in the last year of old scheme). While employers have discretion to make more awards where retirements are few, the evidence indicates that discretion is being used to a limited degree.

12. An added difficulty for employers is that no lower awards have been freed up as a result of higher awards being allocated to lower award holders. For example, if a consultant in receipt of 6 discretionary points is allocated a step 10 award, there is potential for six new clinical excellence awards at local level. However, so far under the new scheme all step 10 awards have been awarded to existing B award holders. This situation will change over time as the pool of B award holders reduces.

13. The cost of the lower award scheme prior to the introduction of the new scheme was £5.5m including employer costs) and the number of points in circulation was 1607. At the end of 2006-2007 the cost of lower awards was around £6.1m with a total of 1698 lower awards/points in circulation.

Higher Awards

14. In the first year of the new scheme (2005-2006) a total of 9 higher awards were made. In the second year 17 awards were made. The cost of the old distinction award scheme was £5.7m (2004-2005) with a total of 127 higher awards in circulation. At the end of Year 2 of the new scheme (2006-2007) the cost was £5.4m with a total of 109 higher awards in circulation. The costs have been contained as all higher awards so far have been allocated to B award holders and no "new" awards have been created.

15. It should be noted that Northern Ireland will be joining the DDRB process (Doctors and Dentists Pay Review Body) and providing evidence for 2008-2009. The DDRB normally makes recommendations on the numbers of "new" higher clinical excellence awards. The numbers are usually linked to the percentage increase in the eligible consultant population.

Concerns

16. The main concerns raised since the introduction of the new scheme have been in relation to the limited number of local awards available for allocation. Concerns have been raised by the BMA and by NICEAC.

17. In NICEAC's first annual report, the Chairman stated "..it was a matter of considerable concern to the Committee to learn that 9 Trusts had indicated that they had not made any local awards this year, apparently for financial reasons, and that the awards that were being made were in many cases very limited. .. ..The rationale for the current scheme is that it should operate consistently and continuously from local to regional level, and it will not be possible for the regional committee to operate effectively and for the scheme as a whole to achieve the purposes for which it was designed unless the appropriate foundations are being laid at local level in terms both of the appropriate number of local awards and their availability to consultants serving in all parts of Northern Ireland".

Options on Lower Awards

18. Below are some possible options on the way forward on lower awards for 2008-2009.

- **Option One** - to continue with the current system. The advantage of this option is that it would continue to help control the cost of the lower award scheme. However, the number of awards available is largely dependent on the number of retirements of current award holders. There will be variations from year to year and across trusts. In a particular year or in a particular trust there may be no retirements and therefore no or few awards to allocate. Trusts may use their discretion to allocate more awards if they have no or few retirements, but the experience to date indicates that, given the current tight financial regime, such discretion is used to a limited degree.

  Can the new scheme operate consistently and continuously from lower to higher level if the current arrangements remain?

  Option Two - to return to the 0.35 national formula (0.35 awards multiplied by the eligible consultant pool equates to the minimum number of awards that should be allocated). The advantage of this option is that it is clear and transparent and easily monitored. Employers and consultants will know exactly how many awards should be made available for allocation. Awards will always be available even if there are no retirements, and it will not be subject to the variation of option 1. However, the original reason for removing the formula would still be relevant. The increase in the number of local awards, given the increase in the eligibility pool, was not sustainable from a cost point of

view. It is likely that the formula would have generated around 290 local awards this year (2007-2008). This compares with 170 points in the last year of the old scheme, and 110 lower awards last year (2006-2007).

It is also worth making the point that that we need to maintain a balance between an automatic uplift each year in the number of awards that are allocated and the need to ensure that such awards are allocated to reflect "excellence" in the medical workforce.

How will these additional costs be met? Will trusts be able to afford a return to the national formula given the higher number of awards generated by this option?

Will the higher number of awards reflect "excellence" in the medical workforce?

- **Option Three** – to introduce a lower formula linking the number of awards to the eligible consultant pool. For example a 0.25 formula would, in the current year (2007-2008), generate around 210 lower awards. This option would be less costly than option 2, and would also retain the advantages of option 2 in terms of transparency and consistency of awards across trusts. However, it would be more costly than option 1 and the number of awards, and hence costs, will increase each year as the eligible pool increases.

  Employers met the cost of lower awards (discretionary points) under the old scheme (170 in the last year of the old scheme). Would employers be able to meet the cost of the number of awards generated by the use of this formula?

- **Option Four** – to link the allocation to the increase in the consultant population. The average increase in the overall consultant population (as opposed to the eligible consultant population) over the past number of years has been around 4%. What would this mean in terms of numbers of lower awards? At the end of 2006-2007 there were a total of 1694 discretionary points or lower clinical excellence awards in the system. A 4% increase would generate 68 lower awards, spread across five trusts (a 2% increase would generate 34 lower awards). This could be allocated on a pro rata basis across the five trusts. This would be in addition to any local awards generated through retirements and any local awards freed up if a consultant in receipt of lower awards receives a higher award.

  This option would help to contain the costs and would be an improvement on option 1 with regard to the overall numbers of awards. However, it is dependent on retirements and an increase in the

consultant population, and in any year the number of awards for allocation may be low if these particular factors are low.

This option would generate fewer awards than options 2 or 3, but more awards than option 1. Would trusts be able to meet the costs of this option?

Would sufficient awards be generated to ensure that the scheme operates consistently and continuously from lower to higher level?

Would the regional committee (NICEAC), in its quality assurance and monitoring role over the local process, be satisfied that it could effectively monitor the outworkings of the local process?

- **Alternative Options** – the Review Group would welcome any suggestions from consultees on any alternative options.

Eligibility

19. The Review Group would welcome any comments on the eligibility criteria for lower and higher awards. A consultant must have completed three years service in order to be eligible for a lower award, and must have achieved four lower awards before being able to apply for a higher award. The threshold for higher awards was set at four lower awards as it was felt that a consultant should be able to demonstrate significant achievement locally before being allowed to apply for a higher award. It should be borne in mind that it would be exceptional for a consultant with only a few lower awards to achieve a higher award. All higher awards so far under the new scheme have gone to B award holders.

Is three years experience as a consultant a reasonable period of time before being eligible to apply for a lower award?

Is the eligibility threshold for higher awards, of four lower awards, reasonable?

Openness and Transparency

20. The Review Group would also welcome any suggestions on how the openness and transparency of the scheme could be improved on. It has been suggested, for example, that CV forms of successful consultants should be made available to other consultants thinking of applying for an award. This would enable consultants to see the sorts of achievements which might merit an award. Alternatively, a small number of anonymised exemplar CV forms could be made available on the website.

Would the availability of CV forms of successful consultants be helpful and how might this work in practice?

Would it be helpful to include a small number of anonymised exemplar CV forms on the Clinical Excellence Awards website?

Levels of Awards

21. In Northern Ireland steps 1 to 9 are decided by employers and steps 10 to 12 are decided by the regional committee. In England step 9 (a bronze award in England) can either be decided by the national committee or by employers. It has been suggested that, in Northern Ireland, step 9 (value £34,200) should be decided by the regional committee (NICEAC), rather than by employers.

The Review Group would welcome any comments on the proposal that NICEAC should consider step 9 awards.

Other Comments

22. The Review Group would welcome comments on any other aspect of the operation of the scheme, both locally and regionally.

Responses on this Paper

23. We are seeking responses to this consultation paper by 29 February 2008. Responses should be sent to John Nesbitt by email at:

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or in writing to:

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ANNEX A

LIST OF CONSULTEES

Chief Executives of HSC Trusts, HSS Boards and Special Agencies

Vice Chancellor of Queen's University Belfast

HR Directors of HSC Trusts, HSS Boards and Special Agencies

Medical Directors of HSC Trusts and HSS Boards

Finance Directors of HSC Trusts and HSS Boards

British Medical Association

British Dental Association

Royal Colleges

Assembly Health Committee

NICEAC

Senior Award Holders