

**REWARDING COMMITMENT AND
EXCELLENCE IN THE HPSS**

**PROPOSALS FOR A NEW CONSULTANT REWARD
SCHEME**

March 2004

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INTRODUCTION

1. In England/Wales a new system of Clinical Excellence Awards is being introduced in 2004. The new scheme replaces the discretionary points and distinction awards schemes with a single more graduated system for rewarding excellent performance by consultants. In Northern Ireland agreement was recently reached on a new contract for consultants. Now would be an appropriate time to carry out a major review of the scheme here with the intention of introducing a new system in 2005.
2. The distinction awards scheme was reviewed in Northern Ireland in 2001. However, this review mainly focussed on the process for deciding awards. While important changes were made, there is a need for a more fundamental review of the scheme, which has remained largely unchanged since its introduction in 1948.
3. Distinction awards are allocated to consultants after scrutiny by the Distinction and Meritorious Service Awards Committee (DMSAC). They are made to reward an outstanding contribution to the HPSS, often for work of national or international significance.
4. Discretionary points were introduced in 1996 to allow greater freedom for local HPSS employers to reward outstanding contributions to local patient care.
5. The aim is to build a new scheme that is as open and transparent as possible, is accessible to all consultants, and that fairly rewards those who contribute most to the HPSS. It must be able to recognise excellent performance across the HPSS. It is also important that any new awards scheme is set in the context of the new consultants' contract.

6. This consultation document sets out the background to the current awards schemes and provides proposals for reform. It sets out a new approach which retains the strongest features of the existing systems and brings in important new elements to recognise outstanding performance.

BACKGROUND TO THE AWARDS SCHEMES

7. The concept of a merit award system was first proposed by the Spens Committee, reporting in 1948 on the remuneration of consultants and specialists for the new NHS. The Committee recommended that three levels of award (A, B and C) be paid to recognise special contributions to medicine, exceptional ability or outstanding professional work.
8. In 1960 the Royal Commission on Doctors and Dentists remuneration extended the system by introducing a fourth level - the A+ award. The proceedings of the awards Committee were carried out in secrecy.
9. In 1979 the Royal Commission on the NHS again reviewed the system. It increased the employer input and changed the confidentiality rules so that consultants could inspect the lists of eligible consultants and awards held.
10. In 1990 further changes were introduced – the introduction of a five year review for new or increased awards; age limits for new awards; more employer involvement; and a new criterion of commitment to service priorities. In 1993 publication of an annual report was introduced to help address concerns about secrecy and unfairness.
11. In 1996 C awards were abolished and replaced with the discretionary points scheme. Discretionary points are decided and funded by local HPSS employers. Local HPSS employers were allowed to award up to five points to consultants at the top of the consultant salary scale. The discretionary points scheme was changed in 2000 to give a new maximum of eight points and to introduce two new service oriented criteria.

12. The Distinction Awards Scheme and the Discretionary Points Scheme are entirely separate with no direct link or relationship between them. There is no requirement that a consultant holds any discretionary points before being considered for a distinction award. The system of discretionary points is outside the remit of DMSAC although the secretariat does monitor the allocation of points by employers to ensure the minimum number of points have been allocated.

Changes introduced in Northern Ireland in 2001

13. In 2001 a review of the Distinction Awards Scheme was carried out in Northern Ireland by an independent management consultant. The review focussed primarily on the process by which awards are decided with the aim of ensuring equality of opportunity for all consultants on the basis of merit alone. Following the review important changes were introduced for the 2001-2002 Awards Round. These can be summarised as follows:

- the introduction of self nomination as the sole method of nomination for an award;
- removal of the upper age limit of 62;
- improvements to the system for monitoring the distribution of awards - to include areas such as ethnic origin and community background;
- changes to the citation process – seeking citations from Royal Colleges for A and A+ awards only;
- changes to the self nomination form and the citation form – now structured on the six criteria for deciding awards;
- improvements to the process for reviewing awards which are subject to a five year review, including the introduction of a five year review citation form structured on the six criteria for awards;

- the introduction of an objective scoring framework for the Committee, based solely on the six criteria for awards; and
 - improving openness by providing information about the scheme on the internet, including the relevant forms, the detailed Guide to the Scheme and the latest annual reports.
14. While a great deal of progress has been made, concerns still remain, particularly in relation to issues of fairness, bias, and a failure to recognise the contribution of consultants in front line patient care. Further changes are needed.

THE AWARDS SCHEMES TODAY

Number and Values of Awards

15. Distinction awards are granted for outstanding contribution to the wider HPSS at regional, national, or international level. They are formally awarded by the Department on recommendations from the Distinction and Meritorious Service Awards Committee (DMSAC). There are currently 127 consultants in receipt of distinction awards (9 A+ awards, 37 A awards and 81 B awards), which represents about 12.5% of the consultant population. The budget for the scheme is around £5m. Distinction awards are freed up and redistributed when consultants retire or leave the service. They stay with a consultant throughout his/her career, subject to a satisfactory five-year review.

16. Discretionary points are awarded for outstanding contributions locally. Discretionary points, unlike distinction awards, can only be granted to consultants at the maximum of the salary scale. They are decided and funded by local HPSS employers. There are around 450 consultants in receipt of discretionary points and the estimated cost is about £4m. Employers must pay a minimum number of points based on the number of eligible consultants they employ. We recognise that the BMA have negotiating rights in respect of discretionary points. However, both parties have agreed it would be useful to include the Department's proposals on discretionary points in the consultation document to illustrate the proposed new scheme.

Eligibility

17. There are around 1000 consultants in Northern Ireland. Eligibility for distinction awards and discretionary points is set out below.

Eligibility for Distinction Awards -

- Practitioners who hold a medical or dental qualification, are fully registered with the GMC, and are employed by a recognised HPSS employer as a consultant.
- Consultants in Public Health Medicine (including Directors of Public Health), Dental Public Health, and Community Child Health.
- Academics and research workers who hold joint appointment contracts.
- Consultants in postgraduate and undergraduate Dean posts (provided they have a joint appointment or honorary consultant position in the HPSS).
- Consultants working as Clinical and Medical Directors of Trusts.
- Consultants employed in the DHSSPS who retain HPSS remuneration arrangements.

Not eligible -

- Locum consultants.

- Consultants employed in full time general management positions such as Chief Executives.

Eligibility for Discretionary Points –

- Consultants on national terms and conditions.
- Consultants on the maximum of the consultant salary scale.
- Academics and research workers who hold joint appointment contracts.

Not eligible

- Consultants in receipt of distinction awards.
- Locum consultants.

18. The current scheme enables a consultant holding a distinction award who, after retirement, is re employed in a substantive HPSS consultant post to continue to be paid his/her award. Payment of an award may continue until aged 70 subject to a review at five yearly intervals.

Assessment Process

Distinction Awards

19. All consultants are invited to self nominate for a distinction award. Self nomination is the only method of nomination for an award. On receipt of a self nomination form, the DMSAC secretariat will seek citations from the appropriate employer (including Queen's University in respect of Joint Appointments), the Senior Award Holder in the specialty, and for A and A+ awards, the Royal College chosen by the applicant. A scoring framework, based on the six criteria for awards, is used for deciding which applicants should be recommended for awards. All six criteria are equally weighted. The six criteria for awards cover the following areas:

- Professional excellence
- Service development
- Administrative or management activities
- Service goals
- Teaching and training
- Research, innovation and improvement of service.

Discretionary Points

20. Employers are expected to consider all eligible consultants and should ensure they have professional input. All consultants are asked to submit a CV form for consideration by a decision making committee. Nominations can also be accepted from elsewhere such as from colleagues and associations. Employers operate their own discretionary points schemes in accordance with broad national guidelines. The

discretionary points committee measures the consultants against the nationally agreed criteria and decides which consultants should receive points and how many. Employers are required to award a minimum number of points per eligible consultant (currently 0.35 points per eligible consultant).

21. There are nine criteria for discretionary points and they cover the following areas:

- Professional excellence
- Significant contribution towards the achievement of local HS service priorities
- Undertaking recognised significant heavy workload or responsibilities in pursuit of local HS service goals
- Contribution to professional and multidisciplinary teamworking
- Research, innovation and improvement in the service
- Clinical audit
- Administrative or HS management contributions
- Teaching and training
- Wider contribution to the work of the HS nationally.

CONCERNS ABOUT THE CURRENT SCHEMES

Distinction Awards

22. There have been concerns about the distinction awards scheme since it began in 1948, particularly on issues of equity and access. It is felt that the scheme doesn't favour certain groups:

- female consultants – female consultants represent about 23% of the consultation population but only hold about 11% of awards;
- certain specialties – there is an apparent higher proportion of award holders in some specialties such as General Medicine and General Surgery, compared with specialties such as Radiology, Pathology, and Mental Illness; and
- consultants based outside the Eastern Board area – the Eastern Board area contains 60% of the consultant population, while consultants in that area hold 80% of all awards. It should be noted, however, that if Joint Appointments are removed from the calculation only 58% of award holders are from the Eastern Board area.

23. There is also concern that the scheme is biased towards academic work. Joint appointments represent about 7% of the consultant population, but hold about 21% of the total awards. Many consider that undue weight is given to a consultant's research record, in particular the number of papers published in peer-reviewed journals which are not separately checked for quality or impact on the HPSS/NHS. Nevertheless, it is important to recognise that teaching, and research and development are essential to delivering high quality health care. It should also be noted that in recent years there has been a significant shift in undergraduate teaching out of Belfast towards other hospitals.

24. There have been concerns expressed about the increase in bureaucracy since the scheme was revised in 2001. While improvements were made to the scheme in terms of issues of equity and access, the changes brought with them an increase in workload, not only for the Committee, but also for citation writers. The self nomination system resulted in a significant increase in the number of applications and consequently in the volume of citations that are required.

Discretionary Points

25. The discretionary points scheme faces many of the same problems as the distinction awards scheme. There are concerns about issues of equality and monitoring. Many consultants feel discriminated against but there is no standard practice in terms of monitoring the results of discretionary points committees.

THE NEW SCHEME

Introduction

26. The review of the scheme in 2001 addressed a number of concerns about the scheme but fundamental criticisms remain. We want to build on the improvements made over the last couple of years. We need a new scheme which addresses concerns about fairness and transparency, and fits the working patterns and developments in the HPSS today.

Summary of the New Scheme

27. The new scheme, like the scheme being introduced in England/Wales, aims to combine the distinction awards and discretionary points schemes as the criteria and goals for both schemes are broadly similar. The separate schemes have given a perception of lower awards for hands on patient care and higher awards for less direct patient contact such as academic and research work. Both have an important role to play in the HPSS.
28. The new scheme will be a single, more graduated scheme. While it will have an increased emphasis on direct contribution to patient care, there will continue to be provision to recognise the importance of research in contributing to the knowledge base of the HPSS and to promoting evidence-based practice. It is intended that the new scheme will be known as the HPSS Clinical Excellence Awards Scheme.
29. Other changes will be introduced to ensure the scheme is as fair and transparent as possible. The criteria for awards will be amended to reflect the aims and objectives of the scheme.

30. The scheme will still include a local and a regional/national element. The lower value awards (formerly discretionary points) will be made by local (employer) committees. They will be known as local Clinical Excellence Awards. These awards will be made for outstanding contributions to local service delivery objectives and priorities. Higher value awards (formerly distinction awards) will be decided by the new Clinical Excellence Awards Committee (CEAC). Assessment for lower and higher awards will be made against the same criteria (see paragraph 43) but, for higher awards, contributions at a regional, national and international level will be taken into account.
31. There will be a single set of eligibility criteria. There will be a single set of assessment criteria with one standard CV self nomination form. Self nomination will be the sole method of nomination at both the local and higher level. There will be a standard process for seeking citations at both levels.
32. As with the current schemes - all awards will be paid in addition to consultants' basic salaries; higher awards will subsume the value of any award held previously; and awards for part time consultants will be paid on a pro rata basis (excluding Joint Appointments). All awards will be annually updated taking into account the recommendations of the Doctors and Dentists Pay Review Body.
33. The number of awards available each year will be limited, particularly at the highest levels. Awards will be decided on the basis of merit.

Rationale and Objectives

34. There is a lack of clarity about the purpose of distinction awards and discretionary points. We propose a rationale and a set of objectives for the new scheme in order to ensure its purpose is clear to everyone.

Rationale

35. The rationale of the scheme will be as follows - the HPSS Clinical Excellence Awards Scheme seeks to reward exceptional personal contributions made by individuals (above the normal expectations of a postholder) towards the delivery of high quality care to patients and to the continuous improvement of HPSS services.

Objectives

36. The objectives (which mirror those of the new scheme in England/Wales), will be to reward individuals who perform over and above the standard expected of a consultant in their post and who locally, regionally or nationally:
- demonstrate sustained commitment to patient care and wellbeing or improving public health;
 - sustain high standards of both technical and clinical aspects of service whilst providing patient focused care;
 - in their day to day practice demonstrate a sustained commitment to the values and goals of the HPSS by participating actively in annual job planning, observing the private practice Code of Conduct, and showing a commitment to achieving agreed service objectives;

- through active participation in clinical governance contribute to continuous improvement in service organisation and delivery;
- embrace the principles of evidence-based practice;
- contribute to knowledge base through research and participate actively in research governance;
- are recognised as exceptional teachers and/or trainers and/or managers;
- contribute to policy-making and planning in health and health care;
- make an outstanding contribution to professional leadership.

37. Individuals will not be expected to meet all of these objectives to be worthy of an award. Much will depend on the nature and type of the post. The above objectives will help inform the proposed new assessment criteria outlined at paragraph 43. The assessment criteria and the weight that should be attached to each of the criteria will need to be made very clear, if the overall aims outlined above are to be met.

We would welcome comments on the above rationale and objectives.

Steps and Values of Awards

38. The proposed steps and values are similar to those being introduced in England/Wales (in England/Wales step 9 can be decided by either the local committee or the national committee). It is proposed that there will be twelve awards. The first eight awards (steps one to eight) will replace the former discretionary points and will be decided by local (employer) committees. The four highest awards (steps nine to twelve) will be decided by the new CEAC. The proposed steps and values (at 2002-2003 prices) are as follows:

	Step	Value
Local Awards	Step 1	£2,500
	Step 2	£5,000
	Step 3	£7,500
	Step 4	£10,000
	Step 5	£12,500
	Step 6	£15,000
	Step 7	£20,000
	Step 8	£25,000
Higher Awards	Step 9	£30,000
	Step 10	£40,000
	Step 11	£50,000
	Step 12	£65,000

39. It will be normal practice for consultants to move progressively from one step to the next. However, local (employer) committees will be allowed to make awards which advance consultants by more than one level in one year. Also, consultants will be able to apply for higher awards (steps nine to twelve) after having achieved at least four local

awards. The values shown for local awards are for illustrative purposes only, and are subject to separate negotiations between the Department and the BMA.

We would welcome comments on the steps and values, in particular –

- **the numbers of steps,**
- **the intervals between the steps, and**
- **the values of the awards.**

Eligibility

40. There are two options in respect of eligibility for local awards. Option one - consultants will be eligible to apply for local (employer) awards when they have achieved at least one year's service at consultant level. Option two – consultants will be eligible to apply for local awards when they have achieved at least three year's service at consultant level. (It should be noted that the current ratio (0.35 per eligible consultant) for deciding the number of discretionary points available may have to be revised if there was any significant change to the number of eligible consultants). It is also proposed that consultants will become eligible for higher awards (steps nine to twelve) after having achieved a minimum of four local awards.

We would welcome comments on the period of eligibility for local and higher awards. In particular, should the period of eligibility for a local award be one year or three years?

Eligibility Criteria

41. In the new scheme employers will be required to confirm that the consultant meets their contractual obligations, particularly with regard to: job planning; consultant appraisal; and observance of the private practice “Code of Conduct”. Employers will also be asked to confirm that no complaints have been upheld following disciplinary action by the employer or the General Medical Council or the General Dental Council.

Assessment Criteria

42. We propose to replace the existing assessment criteria by introducing four new criteria (the four criteria are the same as those being applied to the new scheme in England/Wales). The criteria will be more focussed on the objectives of the scheme as set out in paragraph 36. The new criteria will also ensure a proper balance between service and academic contributions. There is a clear need to increase awards for service achievement, without reducing the recognition of academic and research work. Outstanding contributions by clinical academics and research workers will continue to be recognised within the new scheme.
43. The new assessment criteria will cover the four broad areas listed below. Consultants will be expected to demonstrate, on the application form, their achievements in these four areas.

Area 1 - delivering a high quality service

- Outstanding commitment to achieving HPSS/NHS priorities and objectives including flexibility in adapting to changing priorities and

demands.

- The practical application of high standards in the technical and clinical aspects of their service.
- Provision of patient-centred care, valued by patients and colleagues alike.

Area 2 - developing a high quality service

- Active participation in clinical governance, leading to a major role in the continuous improvement and innovation in the organisation and delivery of services.
- Outstanding commitment to evidence-based practice, which is taken forward appropriately for the benefit of patients through clinical audit/or other evaluative tools.
- Notable additions to the knowledge base of the HPSS/NHS through research and discovery.
- A strong commitment to patient safety, learning from error and promoting safer systems and clinical/research processes.
- Commitment to the development of effective multi-disciplinary team working.

Area 3 - managing a high quality service

- Excellent contributions to policy-making and planning in health and health care, either at a local or national level.

- Excellent achievements in change management.
- Managing a patient centred service.

Area 4 – research, teaching and training

- Excellent achievements in research and development.
- Active participation in research governance.
- Excellent performance as an educator or trainer.

44. The four criteria above will apply to both local (employer) and higher awards (steps nine to twelve). Local awards will be made for contributions to local service delivery objectives and priorities. Higher awards will be made for contributions to regional/national objectives and priorities, and work at a regional, national or international level. Decisions at the local level and the higher level will be made by means of an objective scoring framework. Consultants will not be expected to score highly in all four areas, but an excellent record in Area 1 will be expected if an application is to succeed.

We would welcome comments on the assessment criteria outlined above.

Citation Process

45. We propose a standard process for seeking citations at both local and regional level when a consultant self nominates for an award. Currently, for distinction awards, citations are sought from employers (including Queen's University in respect of Joint Appointments), senior award holders in the specialties, and from Royal Colleges for A and A+ applications. We have identified two options for standardising the citation process.

Option one – we propose that the new CEAC will seek citations from employers and senior award holders for the first two higher awards (steps nine and ten) and from employers, senior award holders and Royal Colleges for the two highest awards (steps eleven and twelve). For local awards it is proposed that citations will be sought from employers (steps one to three) and for the fourth and higher awards, from employers and senior award holders (steps four to eight).

Option two - a citation will be sought in all cases (local and higher awards) from the consultant's employer and then the consultant will be given a choice of one or possibly two further citations from a standard list, a list which might include Royal Colleges and specialist associations.

We would welcome comments on the proposals above on the citation process. In particular, we would welcome comments on whether option 1 or option 2 would be the preferred option.

Committee Membership

Regional Committee

46. The committee includes senior members of the medical profession, as well as representatives from Trusts and Boards, and lay members. At present the committee comprises nine members – three medical members from Great Britain; three medical members from Northern Ireland; two employer members; and one lay member.
47. We propose to reconstitute the committee in order to achieve a better balance between medical and non-medical members, to include more patient representatives, and to include the Chief Medical Officer (or nominee). It will also be the intention to appoint the chairman and any lay representatives by a more open appointment process.
48. The proposed membership is as follows:
- Lay Chairman 1
 - Vice Chairman (Medical Director) 1
 - Chief Medical Officer (or nominee) 1
 - Medical/Dental members HPSS 2
 - External medical members (GB) 2
 - Two employer members 2
 - Two lay members 2
49. This membership will give a better balance between medical and non-medical members. It will be important to have a balance on the committee in terms of gender, ethnic origin, and community background. With regard to medical members it will also be important

to seek to have a balance in terms of specialties represented. The committee's role will be to make recommendations to the Department on applications for higher awards and to monitor the quality of the local awards process.

Local Committees

50. We consider that guidelines should be developed on the membership of local (employer) committees. We propose that the committee established by the employer to make local awards should be comprised as follows:

- Board/Trust Chairman (or non executive director);
- Chief Executive (or director nominee);
- Medical Director (or nominee in cases where there would be a conflict of interest); and
- up to three higher (regional) award holders.

It will also be important on local committees to have a balanced membership in terms of gender, ethnic origin, and community background.

We would welcome comments on the proposed membership of the regional and local committees.

Quality Assurance

51. It is important that there is an effective structure in place for assuring the quality of the awards process given the large sums of public money involved. It is also important that the processes for making decisions are clear and are published, that there is a consistency of approach to decision making, and that there is appropriate equal opportunities monitoring. It is proposed that the new CEAC will take on a quality assurance role with regard to local awards. Employers will be required, through a system of annual reporting, to provide information to the CEAC which will enable quality of procedures and consistency of approach to be checked. The CEAC will report annually to ensure transparency about how it makes its own awards and who receives them. The information received from employers will form part of the CEAC's annual report.

We would welcome comments on the proposal that the new CEAC should take on a quality assurance role with regard to local awards.

Appeals

52. Awards are limited and competition for awards is intense, even more so with the introduction of self nomination when the number of applications increased considerably. At present, a consultant, if dissatisfied with the Committee's decision can ask for an explanation from the Chairman. However, we do not believe this process is sufficient. We propose that the new scheme should have an independent appeals process. An appeals panel will be set up and will comprise three people nominated by the Department and who were not involved in the

original decision. The appeals panel will only consider the process by which the decision was made, it will not consider whether an award should or should not have been made. It is also important that an independent appeals mechanism is in place for local awards.

We would welcome comments on the proposal to set up an independent appeals panel.

Review and Renewal Criteria

53. Awards made by the CEAC will be reviewed at five yearly intervals to ensure that the consultant is continuing to fulfil the criteria for an award. In addition, ALL awards will be reviewed at any time in cases where allegations about a consultant's performance or conduct are upheld through disciplinary or professional fitness to practice proceedings. Employers will be expected to inform the CEAC if an award holder is subject to disciplinary or professional fitness to practice proceedings.

We would welcome any comments about the five year review process.

Retention of Award after Retirement

54. A distinction award holder who, after retirement, is re employed in a substantive consultant post in the same specialty may continue to be paid their distinction award. This practice means that awards that would normally become available for other consultants on retirement continue

to be committed, while the consultant also receives benefit from the value of the award in his or her pension payments.

55. We propose that awards should cease with effect from a consultant's retirement or partial retirement date. In the case of awards made by the new CEAC, the award will then be made available for reallocation to other consultants in the next available awards round.

We would welcome comments on the proposal that awards should cease with effect from a consultant's retirement date.

Joint Appointment Academic General Practitioners

56. It is proposed to broaden the scheme to include joint appointment academic general practitioners. Academic general practitioners are not eligible for distinction awards, unlike academic colleagues in other clinical fields. First class teaching and research in a primary care setting are essential ingredients for a modern health service.

We would welcome comments on –

- **the proposal to include joint appointment academic GPs;**
- **and**
- **the level of awards that joint appointment academic GPs should be considered for.**

Openness and Transparency

57. For the past few years the list of consultants receiving distinction awards has been published in the Committee's annual report. The report is made available to all those with an interest in the scheme and is also available on the DMSAC website. This is important in terms of openness and transparency.

We would welcome any comments or suggestions on how openness and transparency could be further improved.

Equality of Opportunity

58. The Government is fully committed to ensuring equality of opportunity and openness in the operation of any new awards scheme. We will continue to build on the improvements made in this area following the review in 2001. In addition to monitoring of awards by specialty, gender, age and location, the secretariat has started gathering data on ethnic origin and community background. In the new scheme it is proposed that employers will be expected to monitor the outcome of local awards. Employers' monitoring data will be part of the CEAC reporting process and will be included in the CEAC's annual report. Awards will be decided on grounds of merit but the distribution of awards will be monitored closely at both local and at regional level and any unjustifiable imbalances identified and addressed.

We would welcome comments on the proposal that the distribution of *all* awards should be monitored and any unjustifiable imbalances identified and addressed.

Equality Implications

59. Section 75 of the Northern Ireland Act 1998 requires each public authority, in carrying out its functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity -

- between persons of different religious belief, political opinion, racial group, age, marital status, or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

In addition, without prejudice to the above obligation, each Public Authority must also have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

The new proposals outlined in this document aim to improve the system for monitoring the outcome of decisions on awards. It is not envisaged that the proposals will have any adverse impact on the nine Section 75 groups mentioned above.

Transition

60. Details of any transition arrangements will be produced in advance of the new scheme. The new scheme will be an entirely separate scheme and consultants will be expected to apply for the new awards. However, there will be no intention of removing existing awards. Anyone in receipt of a distinction award or discretionary points will be able to retain them subject to existing review provisions. No further awards

will be made under the existing schemes with the introduction of the new scheme.

CONCLUSION

61. Consultants work hard for the HPSS and many do so with great distinction, whether they are delivering service to patients, teaching or carrying out research. The Government recognises this commitment to the HPSS/NHS and wants to reward outstanding contributions by individuals more effectively.
62. For too long the two awards schemes have lent themselves to a perception of bias and unfairness. It is not always clear why some consultants receive awards and why others do not.
63. The above proposals seek to develop a scheme that:
 - is transparent, fair and based on clear evidence;
 - is open and accessible to all consultants;
 - better rewards those who contribute to service delivery and patient care; and
 - better rewards those who contribute most to the corporate goals of the HPSS.
64. We would welcome your views on these proposals. We need to ensure that we are supporting and rewarding the very best of our consultants who - whether through their direct patient care, their teaching, or their research - are making an outstanding difference to the HPSS/NHS.

HOW TO RESPOND

We would welcome comments and views on any aspects of the issues covered in this document. The closing date for receiving comments is **28 May 2004**. Comments can be sent by e-mail or in writing to the addresses shown below.

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DISTRIBUTION LIST FOR CONSULTATION DOCUMENT

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Vice Chancellor of Queen's University Belfast

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