

Regrading to Specialist in Scotland

The Scottish policy source

Calum, the composite Scottish Specialty Doctor encountered earlier in the handbook, has spent years developing a senior scope within an NHS board. He manages complex patients with considerable autonomy, contributes to improvement and is trusted across the multidisciplinary team. He has heard that a new national policy allows Specialty Doctors to be regraded to Specialist, but the accounts he receives vary. One colleague describes an application window that has already closed; another says only doctors on the 2022 contract can apply; a third believes the route is simply competitive recruitment under a new name. None is a safe basis for a career decision.

The operative source checked for this chapter is Scottish Government NHS Circular PCS(DD)2025/02, issued on 2 December 2025 and titled Policy for the Career Progression/Regrading of Specialty Doctor/Dentist to Specialist Grade. It was developed following the 2024 pay settlement and applies across NHS Scotland. Its policy took effect on 1 August 2025 and remains an ongoing route. A source refresh on 12 September 2026 found the circular still identified by current NHS Scotland and BMA guidance as the operative progression route.[95][96] A later amendment or replacement would control, so every applicant should repeat that check.

The policy allows a Specialty Doctor or Dentist to ask the employer to assess the current role against the generic capabilities of the Specialist grade. It rests on two elements: eligibility, including capability, and service need for a Specialist post. When both are established, the doctor or dentist progresses to the Specialist grade. The policy expressly does not replace competitive recruitment into a vacant role, such as a newly created post or one arising when an Associate Specialist leaves.^[95]

The route therefore concerns recognition of a person and role through a national process. It does not mean that any experienced doctor can require an unrelated vacancy to be converted for them. Nor does it require the doctor to enter a recruitment competition simply because the employer has not used the process before. The first question is which situation exists: regrading of an eligible Specialty Doctor under PCS(DD)2025/02, or appointment to a vacant Specialist post. That distinction should appear in the meeting request and every subsequent document.

Scotland introduced the Specialist grade in 2022 as part of SAS contract reform. The grade is an employment status governed by its contract; it remains separate from entry on the GMC Specialist Register.^[97] Successful regrading changes the employment grade but does not award specialist registration, a training certificate or an automatic consultant appointment. Specialist Register entry likewise would not itself complete this employment process.

The December 2025 circular included a transitional backdating arrangement. Successful candidates who applied before 31 January 2026 could have pay backdated to 1 August 2025, provided they met eligibility then. That deadline is now historic. BMA Scotland's current explanation confirms that applications from 1 February 2026 take effect, if successful, from the date first submitted rather than being backdated to August 2025.^[96] A new applicant should not interpret the missed transition as closure of the policy.

Build a Scottish policy record before applying: the circular and annexes, current application form, download dates, written contract, current job description, signed job plan and applicable Specialist terms. The circular links to the official application form and directs personal enquiries to the employing NHS board or relevant national NHS employer.^{[95][98]} Local workforce teams administer the process, but local custom should not silently add an eligibility rule or remove a safeguard from the national policy.

Record policy and pay sources separately. PCS(DD)2025/02 governs the progression process; the Specialist contract governs the resulting employment framework; later pay circulars update scale values. A pay award does not by itself rewrite eligibility or reopen the historic backdating window. This source discipline also prevents a board's application checklist being treated as if it superseded the national circular. Where a local form asks for more material, ask what purpose it serves and preserve the national test.

Eligibility

The policy's scope covers all existing and new Specialty Doctors and Dentists employed in NHS Scotland, regardless of whether they hold a 2008 or 2022 contract, or an earlier staff grade contract.^[95] The written employment position matters. A locally titled doctor whose work resembles an SAS role should not assume inclusion. An Associate Specialist on a closed grade should obtain advice before contemplating a contractual move. The policy is not a general route for every doctor working in Scotland.

Keep the appointment letter and any later contract transfer record. They show both the employing body and the contractual route, particularly where payroll terminology or an old electronic record uses a different label.

Four eligibility requirements appear in section 4. The applicant must have full registration and a licence to practise with the GMC or GDC. They need at least ten years' work, continuously or in aggregate, since obtaining the primary qualification. They need at least six years in a relevant specialty in a current or closed SAS grade; equivalent relevant-specialty experience in other medical grades, including overseas, is accepted. Finally, they must meet the Specialist grade generic competencies framework.^[95]

The ten-year rule is a post-primary-qualification experience threshold. The six-year rule is a relevant-specialty threshold. A period may contribute to both calculations where it genuinely satisfies each, but the two questions must still be answered separately. Produce a chronological table with start and end dates, organisation, country, grade, specialty, working pattern and supporting record. Identify gaps and overlapping jobs. Do not count simultaneous posts twice when calculating elapsed aggregate time.

Overseas and other-grade experience is not excluded merely because the job title differs from a Scottish SAS title. Explain specialty relevance through duties and scope rather than literal title matching. An employment letter may establish dates; a contemporaneous job description, appraisal record, supervisor statement or other suitable record may help establish the nature of the experience. Where documents require translation, use the current application's instructions and a reliable process.

The policy does not convert ten years since qualification or six years in specialty into proof of Specialist capability. Time creates eligibility to be considered only when the other requirements are met. Nor does reaching the top of the Specialty Doctor pay scale complete the test. Conversely, a less-than-full-time pattern or career break should not be treated automatically as lack of capability. The policy uses continuous or aggregate work language, while evidence of current practice remains necessary.

Service need is a separate condition for successful regrading. The BMA's public summary describes applicants as needing to work wholly or substantially at Specialist level, reflecting the policy's principal route for demonstrating service need.^[96] The circular itself places wholly or substantially Specialist-level clinical responsibility in the job plan as sufficient evidence of service need; it does not list it as an additional section 4 time condition. Applicants and panels should work from the circular's structure when deciding the case.^[95]

Use a four-part eligibility check. Part one records grade and contract. Part two records registration and licence. Part three calculates both experience periods with documents. Part four maps every generic capability. Add a separate service-need page. This prevents a common error in which several years of autonomous work are described persuasively but the registration, chronology or capability map remains incomplete.

If the chronology is disputed, frame the question precisely. For example: “Does my three-year overseas specialty post from 2011 to 2014 count as equivalent relevant-specialty experience under section 4, given the attached duties and confirmation?” A precise question invites a reasoned answer. “Do my overseas years count?” encourages an impression rather than analysis.

Where a criterion is not yet met, record what is missing and the earliest realistic review. The policy expects career-development discussions and directs managers to help identify opportunities, potentially including secondments and possible SAS Development Fund support where services can provide them safely.^[95] Eligibility planning should never involve inventing retrospective evidence or recasting unrelated experience as relevant.

Check the licence at the date of application rather than assuming registration once obtained remains unchanged. If practice is divided between specialties, explain which experience supports the relevant-specialty calculation and which current scope is being assessed. A doctor who changed specialties may have ten post-qualification years but fewer than six in the relevant field. A doctor with overseas consultant experience may satisfy the experience test while still needing evidence that the generic capabilities are current and applied in the Scottish role.

Reasonable adjustment belongs in process design, not in lowering the capability standard. An applicant may need accessible documents, additional time in a discussion or a different interview arrangement. Ask medical workforce what is possible and confirm it in writing. Avoid submitting health information beyond what is required to explain the adjustment. Where absence has affected access to evidence, distinguish the evidential issue from the underlying capability and identify an appropriate way to demonstrate current practice.

Specialist capability in Scottish context

The Scottish policy adopts the generic Specialist grade capabilities and includes detailed appointment guidance in Annex C. The domains cover professional values, behaviours, skills and knowledge; leadership and

teamworking; patient safety and quality improvement; safeguarding; education and training; and research and scholarship.^{[95][6]} They define transferable expectations across specialties; the evidence must still be rooted in Calum's actual scope.

Begin with the role before the documents. State patient group, setting, procedures, decisions, frequency, continuity responsibility, governance, escalation and boundaries. A Specialist can be autonomous within defined competencies without claiming the whole breadth of a consultant role or curriculum. The circular's capability material expressly recognises autonomy within local clinical-governance frameworks. A clear limit is evidence of mature practice when it shows how the doctor obtains help safely.

Clinical capability is demonstrated by judgement, not by case count alone. Calum's activity data show substantial exposure, but selected non-identifiable examples show how he manages uncertainty, balances competing risks, revises decisions and involves patients. His job plan and a senior colleague's confirmation establish that this is authorised recurrent practice rather than isolated acting up. Recent appraisal material shows reflection but is not used as if the appraiser directly assessed every clinical skill.

Leadership evidence should show behaviour and result. Calum identifies an unsafe handover variation, brings professions together, tests a clearer process and reviews its effect. Terms of reference and an approved report establish his role; team feedback describes how he worked. He does not claim sole ownership of a multidisciplinary outcome. Formal courses may support knowledge, but attendance alone does not establish the capability to collaborate, challenge, decide and learn.

For quality and safety, follow the complete improvement trail. Identify the problem and baseline; show the doctor's contribution to intervention and evaluation; record what changed and what remains uncertain. Complaints, incidents and difficult outcomes can provide strong learning evidence when handled with confidentiality and balance. A successful project is not required in every example. The ability to recognise weak results and adjust practice is itself important.

Education is Calum's thinnest domain. He teaches informally and supports new colleagues, but he has no record of planning a programme, observing a learner or evaluating teaching. He should not turn frequent helpful conversations into a claim of formal educational leadership. He maps what the existing evidence supports—team learning and informal feedback—and identifies the part that still needs observable activity.

The solution is not necessarily a lengthy qualification. With his manager and educational lead, Calum agrees to identify a learning need, plan a short multidisciplinary teaching sequence, obtain observation and learner feedback, revise the second session and produce an approved evaluation. The job plan records preparation and delivery time. This creates evidence of a complete educational contribution while addressing a genuine service need. If formal supervision later becomes part of the role, its training, authority and support can be agreed separately.

Research and scholarship should be interpreted through the framework, not through an assumed publication quota. Evidence may include critical appraisal, use of guidelines, communication of research to patients, application of evidence in a local pathway, presentation or publication, and recognition of unanswered questions. Calum uses a guideline implementation project to show how he appraised evidence, explained uncertainty and evaluated application. He labels the project accurately rather than presenting it as original research.

Annex C lists multiple possible evidence sources, including job plans, logbooks, personal audit, appraisal material, multisource and patient feedback, reflective work, courses, references and interview. It says applicants should be able to demonstrate suitability by any means available and expects evidence from more than one source. It also describes references including one from the most recent job by a senior doctor on the GMC Specialist Register with whom the applicant worked, and from the clinical manager.^[95] Check the current form for how these should be supplied.

Use a capability map with the fields: framework item; narrow claim; evidence; observer or verifier; impact or learning; date; and gap. Mark evidence as current, contextual or historic. A twenty-year-old achievement can explain development but should not be allowed to obscure present scope. A blank cell is more useful than a weak certificate when it triggers a real opportunity and review date.

Apply a proportionality test to every attachment. Ask whether it adds a new fact, corroborates a material claim or helps the panel understand context. If it does none of these, omit it from the main bundle. A concise index can list available supplementary material without overwhelming the application. Redact only through an authorised method and keep the unredacted organisational original in its proper system; the personal portfolio should not become an uncontrolled clinical archive.

Finally, test consistency across the job plan, application and referee accounts. If the application says Calum independently leads a service while

the job plan records only supervised sessions, the difference needs explanation or correction. It may reflect an outdated plan, an overstatement or a genuinely changed role. Resolve the discrepancy openly. Panels can assess complexity; they cannot safely infer which conflicting document is accurate.

Starting the process

The policy expects Specialty Doctors, Dentists and line managers to discuss career development during regular appraisal and job planning, especially when experiential criteria have been met. These conversations help identify capability development. They are not themselves an application or decision. Calum begins the formal route by requesting a meeting with his line manager once he considers that he can demonstrate eligibility.^[95]

His written request names PCS(DD)2025/02 and the purpose: “I would like a meeting under section 6.2 to progress an application for regrading to Specialist. I will provide my eligibility chronology, defined-scope statement, capability index and service-need summary. Please confirm the current form and the medical workforce contact.” This creates a clear start without turning the email into the full application.

The meeting should be constructive and supportive. Calum may ask a BMA representative or work colleague to attend as an observer. The normal expectation in the circular is a one-to-one meeting with the manager, and the accompanying person does not take an active role.^[95] Clarify arrangements in advance. The policy role of observer should not be confused with any separate right to union advice outside the meeting.

The manager considers the evidence and discusses service need with the Clinical Director. If supportive, the manager assists with the career progression and regrading form and supplies a statement explaining how the eligibility criteria have been met. Where several doctors in a team apply, each application must be considered on its own merits.^[95] Comparative scarcity should not replace individual application of the criteria.

If the manager does not support the request, they must confirm the position and reasons in writing within five working days of the meeting. The reasons should identify which eligibility elements have not been met or demonstrated. Calum may still submit the form, attaching the non-support reasons.^[95] Managerial disagreement is therefore evidence for the panel to consider, not an absolute veto.

Where non-support concerns experience, skill or autonomous practice rather than absent service need, the manager and applicant should identify development areas and an action plan through the PDP. Once those areas are

achieved, the applicant can restart the application discussion.^[95] Write the plan with activity, supervision, time, product, standard and review date. Identify what the board must make available. A plan containing only “gain more experience” cannot show when readiness will be reassessed.

Calum provides four concise documents for the meeting: an eligibility page, a two-page defined-scope and capability summary, a service-need statement and an indexed evidence list. He also identifies the education gap himself. That admission helps the conversation focus on whether his existing teaching evidence meets the framework and, if not, what proportionate activity will resolve it. It is stronger than burying the weakness among certificates.

Send a factual follow-up after the meeting: participants, evidence reviewed, agreed and disputed points, manager decision, expected written reasons or statement, development actions, owners and dates. Ask for corrections. The note protects continuity if managers change and gives medical workforce a traceable history without turning every difference into a formal dispute.

If service need is questioned, ask the manager and Clinical Director to identify whether the dispute concerns the level of responsibility, the persistence of the function, its location, or the evidence that it is required. “The board has no plan for another Specialist” is not the same proposition as “this work does not require Specialist responsibility.” The policy requires the actual service question to be explored. An applicant should provide data and role evidence, while recognising that workforce planning remains an employer responsibility.

Use the meeting to agree handling of higher-level work while the application is considered. If the work is in the job plan, confirm that the plan remains accurate. If it sits outside the plan, the circular's immediate-review provision becomes relevant. The response should protect patient care and avoid either abrupt unsafe withdrawal or indefinite invisible extension of duty. Record who will review the position and when.

Evidence and assessment

The completed form is sent to the employer's medical workforce team, which arranges the panel. Medical workforce confirms receipt to the applicant and line manager and gives the timescale for the next stage.^[95] The receipt date is operationally important: it starts the policy assessment timetable and, for a successful contemporary application, becomes the regrading implementation date.

The panel includes at least one senior independent clinical lead, a staff member with clinical oversight of the relevant team and an HR member. The circular does not require all three to be external. The combination is intended to bring independent senior judgement, knowledge of the service and process expertise. Raise any conflict promptly, specifying the relationship and why it may affect fair consideration rather than making a general accusation.

All material needed should be in the form. Start with a one-page map: grade, contract, registration, eligibility dates, defined scope, capability conclusion and service-need conclusion. For each framework capability, state a proportionate claim, identify two or more suitable evidence sources where possible and explain impact or learning. Use exact page or section references. A panel should not have to search an unindexed drive for the argument.

The circular's evidence model values triangulation. A job plan shows agreed work, a logbook shows activity, an observed account shows performance and a quality report shows effect; no one of these establishes everything. References should remain within the referee's knowledge. A clinical manager can confirm the governance and recurring role. A colleague who directly observes practice can describe decisions. Neither should be asked to endorse results they have not reviewed.

Service need requires its own evidence. Under the Scottish policy, wholly or substantially Specialist-level clinical responsibility already recorded in the job plan is sufficient evidence. Examples include independently conducted clinics or theatre lists, even under a named consultant, and the circular extends the principle to generalist or advisory contributions that demonstrably affect patient care, pathways or service delivery, such as guideline writing or teaching.^[95] The evidence should still define the responsibility and its recurrence.

If higher-level elements occur beyond the job plan, the policy calls for an immediate job-plan review to decide whether the department requires them and to adjust the plan to the outcome.^[95] This is a significant safeguard. It avoids a false choice between accepting invisible higher-level work indefinitely and asserting that undocumented work can never count. Record what is happening, decide whether it is needed, and align the plan or the work accordingly.

The panel may accept, reject or request further information within twenty working days. If more information is requested, the period may extend to a maximum of thirty working days from medical workforce's original receipt. The extra information can include a discussion with the panel. No applicant

may be rejected without first being invited to a discussion, although a discussion is unnecessary for acceptance where the written form is sufficient.^[95]

At a panel discussion, the applicant may be accompanied by a BMA representative or work colleague, but that person takes no active part.^[95] Prepare the applicant's own answers. Calum rehearses six evidence stories: complex clinical judgement; recognition of limits; collaborative leadership; a complete improvement cycle; education; and critical use of evidence. Each answer distinguishes his action from the team's action and points to the submitted record.

Questions about a weak domain should be answered honestly. Calum explains the informal teaching he has undertaken, the absence of a previous structured evaluation, and the new observed programme. If the new evidence is complete before submission, he includes it. If not, he does not describe a plan as an achievement. The panel must decide current eligibility; insight and future plans cannot substitute for a capability that the framework requires.

Further-information requests should be controlled through a query log: exact request, policy issue, document owner, lawful source, due date, submitted response and confirmation. Where patient or colleague information is involved, use anonymised or approved material. If the requested evidence cannot lawfully be copied, explain the restriction and seek an authorised summary or verification. Never recreate a missing contemporaneous record as if it were original.

Before final submission, perform a traceability audit. Underline every claim using words such as *led*, *independently*, *designed* or *implemented*. Locate its support and ask whether the evidence proves that verb. Then ask an unfamiliar reviewer to describe Calum's scope and service need from the first three pages. If their account is wrong, reorganise the material rather than simply adding pages.

A service-need sheet can use six headings: function; Specialist-level responsibility; where recorded in the job plan; frequency and duration; effect on patients or pathways; and corroborating source. Where the need is prospective rather than already delivered, add workforce evidence and explain why Specialist responsibility is the proportionate model. Do not rely only on workload volume. A very busy service may need more capacity without necessarily needing a different grade; the application must explain the level of decision and accountability.

Prepare a clarification pack before the panel asks for it. Keep authorised summaries of activity, the relevant job-plan pages, referee contact details, a

list of acronyms and a one-page capability cross-reference. This does not mean submitting everything pre-emptively. It allows a prompt, controlled response and reduces the risk that a short deadline leads to disclosure of irrelevant confidential material.

Timescales and decision

The Scottish route has several distinct clocks. Combining them into a single remembered “twenty days” rule creates errors. Make a dated timeline and label each event with the wording of PCS(DD)2025/02. Working days exclude ordinary weekends, but applicants should not calculate Scottish bank holidays or board closures without confirmation from medical workforce.

First, after the line-manager meeting, written reasons for non-support are due within five working days. Second, after medical workforce receives the application, the panel considers it and accepts, rejects or requests information within twenty working days. If information is requested, this assessment period can extend to no more than thirty working days from original receipt. Third, the policy separately requires the entire application to be fully considered and the outcome confirmed within thirty-five working days of that original receipt.^[95]

These are policy requirements, not reasons to assume that no administrative delay can occur. Preserve the receipt and calculate an indicative date. If the panel requests information, ask whether the overall thirty-five-day outcome date remains expected. If a date passes, follow up in writing with the actual sequence, ask for an explanation and revised date, and seek advice where delay is material. Do not withdraw or resubmit casually, because the submission date affects implementation.

If rejected, the invitation to panel discussion must occur before that rejection. The applicant can therefore check whether the safeguard was observed. An interview or discussion does not restart the application automatically. Record the date, attendees, questions and any additional material authorised for consideration. Afterwards, send corrections promptly if the panel's summary contains a factual error.

The decision should allow the applicant to identify the finding on eligibility and the finding on service need. It should state whether evidence was insufficient, a criterion was not met, or the service proposition failed. The policy requires detailed in-person feedback after rejection, followed by the reasons in writing and, where applicable, areas for capability improvement.^[95] A bare unsuccessful notification is not enough to support the development response described by the policy.

For a rejected contemporary application, the appeal must be lodged in writing with the employing board's Medical Director within twenty working days of the written outcome. The appeal panel must meet within twenty working days of receiving the written appeal. Written submissions are due one week before the hearing, and the appeal decision is due within fifteen working days after the hearing.^[95] Record the actual instructions in the decision letter and obtain confirmation of receipt.

The historic transition should appear separately on the timeline. Applications before 31 January 2026 had the potential August 2025 backdating if successful and eligible at the earlier date. It is not a recurring annual window. Since 1 February 2026, the current position described by the circular and BMA is an ongoing policy with successful regrading effective from submission.^{[95][96]}

A useful timeline sheet has columns for event, policy interval, actual date, indicative due date, confirmation and follow-up. It is a control aid, not a legal deadline calculator. If correspondence, illness, agreed extension or an amended policy affects a live case, obtain individual advice. Never rely on a date calculated from this chapter when the current decision letter gives specific instructions.

Work through an example without turning it into a universal calendar. If medical workforce records receipt on Monday 7 September, day counting begins under the employer's method and must take account of Scottish public holidays and closures. The applicant can enter indicative dates for twenty, thirty and thirty-five working days, then ask medical workforce to confirm them. This is better than announcing a deadline calculated by ordinary calendar days or assuming every board observes identical closure days.

The relationship between the thirty-day extension and thirty-five-day final requirement also needs care. The policy permits more time for further information but still states that the complete outcome is to be confirmed within thirty-five working days of original receipt. An information request should therefore identify what is missing and when it is due. The applicant should respond promptly, record any agreed variation and ask how the overall outcome timetable is affected.

Do not treat a missed target as automatic approval, automatic rejection or automatic entitlement to compensation. The policy does not say that. It creates an accountability point for follow-up and, where necessary, advice. Continue to meet requests and preserve evidence while raising delay through the appropriate medical workforce, management or representative route.

Outcome job plan and pay

Where the panel accepts the application, the doctor or dentist is regraded to Specialist. For current applications, implementation is the date the form was submitted to medical workforce. The policy says a required job-plan review should not delay regrading.^[95] The submission receipt is therefore a key record for HR and payroll.

The earlier transitional arrangement is different. A qualifying successful application submitted by 31 January 2026 could be backdated to 1 August 2025 if the applicant met eligibility at that date. BMA guidance explains that applications on or after 1 February 2026 are effective from the date first submitted.^[96] Do not ask payroll to use the historic date for a later application unless a specific amended provision applies.

The job plan may require review when the existing plan is incompatible with the Specialist contract's working limits or when additional or different duties are involved. Separate three questions: what work already justified the application; what changes are required by the new contractual framework; and what genuinely new work the service proposes. Regrading should not become a device for adding an unbounded portfolio of duties without time, support or agreement.

The revised plan should specify clinical and non-clinical activity, locations, on-call commitments, objectives, governance, support, resources and review. It should preserve both Specialist and Specialty-level service work where the role legitimately contains both. Senior grade does not mean every activity must be labelled higher-level. Routine work may remain an important part of continuity, while the plan makes the senior responsibility visible and deliverable.

Lack of an identified budget for increased regrading costs is not sufficient grounds for refusal under the Scottish policy.^[95] That rule does not make payroll mechanics irrelevant. The employer must still issue the contractual change and apply the correct scale. BMA guidance says a regraded doctor will normally enter at the bottom of the Specialist scale and notes that the scale has further pay points, but the applicable contract, recognised service and individual notification must be checked before concluding the starting salary.^{[96][97]}

Ask for an effective-dated pay statement showing grade, point, arrears, pensionable pay and implementation date. Compare it with payslips after processing. National pay awards may change scale values without changing the policy mechanism; a September 2026 salary table should not be embedded as if permanent. Where the calculation or prior-service treatment is disputed, obtain contractual or union advice promptly.

After regrading, update the professional portfolio, appraisal scope and organisational records. Revalidation continues. The GMC register status remains unchanged unless the doctor separately completes a regulatory route. Local authority to supervise, manage budgets or hold a statutory function must still be delegated appropriately. Specialist employment recognises senior capability in the agreed role; it is not an unlimited warrant.

Use an outcome implementation checklist: written decision; effective date; HR variation or new contract; salary and arrears; pensionable-pay check; job-plan review; governance and credentialing; reporting lines; appraisal scope; objectives and development; communications; and a three-month review. The last review catches discrepancies that were not visible on the effective date.

If capability is not established, the policy expects detailed feedback and, where appropriate, a development plan supported by the board. If service need is also absent, the job plan should still be examined where the application relied on ongoing higher-level work. A negative outcome cannot safely coexist indefinitely with an expectation that the doctor continues responsibilities the employer says are not required or recognised.

Where the panel finds service need but not present capability, distinguish development of the existing doctor from recruitment to a vacant post. The Scottish circular's stated outcome section describes detailed feedback and board support rather than the four-outcome architecture used in Wales. The employer may still need to manage an immediate service gap, but the applicant should not import the Welsh "slotting" outcome into the Scottish decision. Ask the board to state its chosen workforce action and the doctor's development path separately.

The implementation conversation should also cover communication. Colleagues need enough information to understand reporting and clinical responsibility, but the application evidence and panel discussion are not ordinarily a team-wide document. Agree a brief factual announcement of grade, scope and effective date. Protect personal and third-party information, particularly material drawn from feedback, health records or employment advice.

Set a review approximately three months after implementation. Check that the contract, payroll, job plan, rota, directory, appraisal scope and governance records all show the same role. Resolve discrepancies before they harden into custom. This review is practical good administration rather than another policy gateway.

Review appeal and reapplication

An unsuccessful applicant may appeal in writing to the employing board's Medical Director within twenty working days of the written outcome, setting out the disputed points.^[95] Read the outcome immediately and protect that period. Informal reassurance, further appraisal discussion or an attempt to improve the bundle does not automatically extend the appeal deadline.

The appeal panel meets within twenty working days of receipt. It includes an appropriate senior clinical lead, a member nominated by a BMA Local Negotiating Committee from a different health board and a senior HR member. The HR representative supports the chair and process. No member may have been involved in the application; where a conflict exists, an appropriate representative from another board can attend. Advice from the relevant Royal College SAS representative should be considered where specialty knowledge would assist.^[95]

The applicant can present personally or with representation. Either side may call relevant witnesses, and written submissions must arrive one week before the hearing. The decision is due within fifteen working days after the hearing. If the appeal succeeds, implementation is backdated to the date the form was submitted to medical workforce.^[95] These provisions make preparation and accurate receipt dates important.

An appeal is strongest when organised by material ground. For each point, record the decision under challenge, the relevant policy provision, evidence submitted, alleged factual or procedural error, its effect and the remedy sought. Examples might include miscalculation of relevant experience, failure to consider indexed evidence, conflation of capability and service need, or a panel-process defect. Dissatisfaction alone does not explain why the decision should change.

Distinguish an appeal issue from a development gap. If Calum had submitted no adequate evidence for the education capability, later completion of a teaching project might support reapplication more naturally than prove that the original panel erred. If the original bundle already contained direct evidence that the panel overlooked, an appeal may be appropriate. A union adviser can help assess contractual process; a specialty-informed colleague can test the clinical evidence. Neither substitutes for the formal decision-maker.

If reapplication is chosen, retain the original form, evidence bundle, decision and feedback. Make a response schedule: each reason, required action, employer support, evidence product, completion date and review. Update service need as well as capability; services change. Do not attach more material without showing which previous concern it answers.

Calum's education gap is resolved through the observed, evaluated programme agreed at job planning. He obtains an authorised confirmation from the educational lead and adds reflection on feedback. His updated map still avoids claiming formal supervisor capability beyond the activity. Meanwhile, his Clinical Director confirms that his substantially Specialist-level clinical responsibilities appear in the job plan and remain required. Capability and service need are now independently traceable.

The manager supports his application. Medical workforce confirms receipt; the panel seeks one clarification about scholarship and then accepts. The regrading takes effect from the receipt-linked submission date, not the historic August 2025 date. Calum's revised job plan records senior clinical responsibility, continued routine work and proportionate education time. Payroll supplies the effective-dated calculation. His GMC register entry does not change.

Had the manager declined support, Calum could still have submitted with the written reasons. Had the panel rejected him, he would have obtained detailed feedback, classified each issue and protected the twenty-working-day appeal period. The Scottish tool therefore has three parts: an eligibility and evidence checklist; a dated process timeline; and an outcome planner connecting decision, contract, job plan, pay and development.

Scotland and Wales should not be collapsed into one “regrading” template. Scotland uses ten years since primary qualification; Wales uses twelve. Scotland requires wholly or substantially Specialist-level work in the job plan for its sufficient-evidence rule; Wales refers to wholly or partially Specialist-level clinical responsibility. Their panels, timelines and negative outcomes differ. A reader moving between nations must start again with the operative policy. The transferable method is narrower: identify the jurisdiction, separate capability from service need, make claims traceable, keep the submitted version and turn every outcome into documented action.