

The consultant handbook for Scotland 2022



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1

Introduction – information at your fingertips

Welcome to the Consultant Handbook for Scotland, online for quick access to regularly updated information and guidance. We have published this as a handy guide to the main contractual issues that may arise in your employment. It brings together an enormous amount of information, advice and guidance on many of the important issues that govern your working life.

This handbook applies to NHS consultants in Scotland. Although much of the information is relevant to medical academic consultants with honorary NHS contracts, they should refer to the [Medical academic page](#) on the BMA website.

Feedback

We are happy to receive any comments on the handbook, or any suggestions on how to improve it or how to improve the services provided for consultant members. Comments should be [emailed to SCC](#).

Whatever your question, we would suggest that this handbook is a good place to start looking for the answer. If you do need more information or help from the BMA, please don't hesitate to get in touch. After all, we are here to support you.

To help us help you, please remember to keep your BMA membership and contact details [up to date](#).

Contacting the BMA

The BMA is dedicated to supporting its members in virtually all aspects of their professional lives. For all your employment advice and information, please call a BMA adviser on 0300 123 1233 between 8.00am and 8.00pm, Monday to Friday excluding bank holidays, or [email your query](#) anytime. Calls cost the same as geographic numbers starting 01 or 02.

Members should always call the above number in the first instance. Your enquiry will be dealt with efficiently by our resident team of employment experts, with most queries being answered directly over the phone or by return email.

If, after contacting the above number, it is found that you need direct representation locally, you will be referred to a member of our member services team.

Wellbeing support services

Confidential counselling and peer support for all doctors and medical students, available 24/7. Call 0330 123 1245 or [find out more](#).

BMA employment advisers

Call 0300 123 1233

[Email a BMA adviser \(support@bma.org.uk\)](#) [Web chat live with a BMA adviser](#)

[Tweet](#) at or [Facebook](#) message a BMA adviser

Message our twitter or Facebook accounts to contact an adviser for assistance or to arrange a call back. Do not disclose any personal identifiable information about third parties when posting public messages via Twitter or Facebook.

2

Employment of consultants

NHS boards

The vast majority of consultants working in the NHS in Scotland are employed directly by NHS boards. These boards must comply with the statutory position in relation to their powers to employ staff. This means that, where pay and conditions of service for a class of NHS staff have been agreed in negotiations and approved or authorised by Scottish ministers, boards must employ such staff on those terms and conditions. Where boards want to employ staff on non-approved terms and conditions, for example, for recruitment and retention to a specific post, then they can apply to Scottish ministers for an order allowing a variation. Subject to any variation which might be granted by ministers, all new staff must be employed on nationally approved terms, pay and conditions.

Local and national negotiations

The 2004 consultant contract in Scotland was negotiated between BMA Scotland and SGHSCD on behalf of employers and any changes to its terms and conditions must therefore be negotiated and agreed in Scotland.

The BMA has worked hard to ensure that medical staff have appropriate local negotiating machinery in NHS boards to complement the UK and national structures. The role of these local negotiating committees (LNCs) is to ensure that national TCS are applied, to provide a formal mechanism to negotiate any proposed changes to local contractual arrangements and to negotiate around any local flexibilities that exist in national agreements. All boards have an LNC consisting of doctors elected by their colleagues to negotiate with management. Where LNCs have been set up according to BMA guidelines the representatives are formally accredited by the Association. This means that they receive advice and support from BMA staff, and receive training in negotiating skills and are protected by trade union law.

For more information on the LNC in your area and details of how to contact your local LNC representatives please log on to the BMA website at <https://www.bma.org.uk/what-we-do/local-negotiating-committees/local-negotiating-committees/get-involved-with-your-lnc>

Consultant contracts

The following sections deal with the contract and TCS for NHS consultants employed under the 2004 consultant contract. The pre-2004 national consultant contract is not covered, given that the vast majority of consultants in Scotland are on the 2004 contract. Consultants who remain on the old contract can obtain advice on its provisions by contacting the BMA.

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The 2004 consultant contract

Since 1 April 2004, the '2004 consultant contract' has been the only contract permissible for new NHS consultant posts, including locums. Consultants in post before 1 April 2004 had, and still have, the choice of moving on to the 2004 contract or remaining on the previous contract. Consultants working as clinical directors or directors of public health are covered by the 2004 contract.

INFORMATION

[2004 consultant contract](#)

The basic work commitment

The contract is based on a full-time work commitment of 10 programmed activities (PAs) per week, each having a timetabled value of four hours (or three hours if the PA is undertaken in premium time – see below). Each consultant must have a job plan that sets out the number of agreed PAs the consultant will undertake, plus a list of the duties they are expected to perform within those PAs.

A key feature of the contract is that it provides a clear maximum commitment to the NHS, including work done while on call. Any additional work above 10 PAs will be by agreement and paid at the appropriate rate. There are additional conditions applying to consultants wishing to undertake private practice.

INFORMATION

TCS, section 4

The working week

A full-time consultant's job plan of 10 (or more) PAs will consist of work from any of the following categories as defined in the TCS:

Direct clinical care (DCC): includes emergency duties (including emergency work carried out during or arising from on call), operating sessions, pre- and post-operative care, ward rounds, outpatient clinics, clinical diagnostic work, other patient treatment, public health duties, multi-disciplinary meetings about direct patient care, administration directly related to patient care (e.g. referrals, notes, complaints, correspondence with other practitioners), on-site medical cover, any other work linked to the direct clinical care of NHS patients and travelling time associated with any of these duties. Emergency duties (both predictable and unpredictable) will be given first priority when allocating PAs for direct clinical care.

Supporting professional activities (SPA): includes continuing professional development, teaching and training, management of doctors in training, audit, job planning, appraisal, revalidation, research, contribution to service management and planning, clinical governance activities, any other supporting professional activities, and travelling time associated with these duties.

Additional responsibilities: are duties of a professional nature carried out for or on behalf of the employer or the Scottish Government, which are beyond the range of the supporting professional activities normally to be expected of a consultant. Additional responsibilities are Caldicott guardians, clinical audit leads, clinical governance leads, undergraduate and postgraduate deans, clinical tutors, regional education advisers, formal medical management responsibilities, other additional responsibilities agreed between a consultant and his/her employer which cannot reasonably be absorbed within the time available for supporting professional activities and travelling time associated with these duties. This is not an exhaustive list.

Other external duties: They comprise work not directly for the NHS employer, but relevant to and in the interests of the NHS. Examples include trade union and professional association duties, acting as an external member as a consultant appointment committee, undertaking assessments for NHS Education for Scotland, NHS Healthcare Improvement Scotland or equivalent bodies, work for the royal colleges, work for the General Medical Council (GMC) or other national bodies concerned with professional regulation, NHS disciplinary procedures, NHS appeals procedures and travelling time associated with these duties. This list of activities is not exhaustive.

It is SGHSCD policy to encourage NHS employers, as part of a corporate commitment to NHSScotland, to release consultants wherever possible for work that is not directly for the NHS employer but is relevant to and in the interest of the wider NHS and which may involve consultants being away from their employment base. Where agreement cannot be reached, the mediation or appeals processes can be used.

The job plan will set out the number of PAs for each of the different types of activities above. It will also set out the duties the consultant is expected to perform within those PAs. See the job planning section for more information on job plans.

INFORMATION

TCS, section 4

Balance of activities

The contract sets out that in a 10 PA job plan for a full-time consultant, there will be 7.5 PAs of direct clinical care and 2.5 PAs of supporting professional activities **unless otherwise agreed**. There is flexibility to agree a different balance of activities. For example, if a consultant has additional responsibilities to carry out, such as being a clinical governance lead, they may reduce their DCC activities to fit this additional work into a 10 PA job. Alternatively, they may agree to undertake extra PAs in addition to the standard 10 per week. It is recognised that less than full-time consultants need to devote proportionately more of their time to supporting professional activities, for example, due to the need to participate in continuing professional development to the same extent as their full-time colleagues. The minimum requirements for appraisal and revalidation are the same for all consultants regardless of the total number of PAs worked. The following table sets out the balance between DCC PAs and SPAs for less than full-time consultants as stipulated in the contract.

Total number of PAs	Number of SPAs
2 or less	0.5
2.5–3.5	1
4–5.5	1.5
6–7.5	2
8 or more	2.5

The SCC's position, which is supported by the UK Academy of Medical Royal Colleges, is that the vast majority of consultants, new and existing, require at least 2.5 SPAs if they have any teaching, training, research, service development, clinical governance or management responsibilities. If employers offer a different balance between DCC and SPA activities, you should refer to the BMA's guidance on [job planning](#). For any specific query relating to job planning contact your [LNC](#)

INFORMATION

TCS, paragraphs 4.2.1 and 4.2.2

Emergency on-call work

The job plan should set out a consultant's duties and responsibilities in respect of emergency on-call work. Under the contract, emergency work is recognised in three ways.

On-call availability supplement

Consultants on an on-call rota are paid an on-call availability supplement in addition to basic salary, which recognises the inconvenience of being on a rota and the duty to participate in it. The level of supplement depends on the rota frequency and the typical nature of the response:

- Level 1 applies to a consultant who needs to attend a place of work immediately when called, or to undertake analogous interventions (e.g. telemedicine or complex telephone consultations).
- Level 2 applies to a consultant who can attend a place of work later or respond by non-complex telephone consultations later. (It is possible for a consultant on level 2 availability supplement to agree with their employer not to be contactable immediately for short intervals, provided that there are arrangements for any messages to be taken and for the consultant to be able to respond immediately after the interval in question.)

Frequency of rota commitment	Value of supplement as a percentage of full-time basic salary	
	Level 1	Level 2
High frequency: 1 in 1 to 1 in 4	8.0%	3.0%
Medium frequency: 1 in 5 to 1 in 8	5.0%	2.0%
Low frequency: 1 in 9 or less frequent	3.0%	1.0%

If less than full-time consultants participate in the rota on the same basis and as frequently as their full-time colleagues, they will receive the same percentage supplement of the whole-time equivalent salary. However, if they participate in the rota on a different basis, they will receive the percentage supplement that a consultant on an equivalent rota would have received. For example, if a less than full-time consultant was on level 1 and worked a one in 10 rota whereas their full-time colleagues worked a one in five, they would receive the low frequency supplement of 3.0 per cent: they would not get half of a 5 per cent supplement.

In calculating the frequency of the rota, it is important to take into account prospective cover rather than taking the frequency to be equivalent to the number of people taking part in the rota. Prospective cover will result in an increase in the frequency of the rota commitment. For example, a one in 10 or one in nine rota with prospective cover will be pushed into the medium frequency, becoming at least a one in eight rota, and a one in five rota will be in the high frequency, becoming a one in four rota. This is based on the formula: rota after including prospective cover is one in (number on rota x 42/52).

INFORMATION

TCS, paragraphs 4.10.9-4.10.15

PA allocation for emergency work

The on-call availability supplement recognises the inconvenience of being available while on call. It does not recognise the work actually done while on call. The contract explicitly takes account of the work done by allocating an appropriate number of PAs within the weekly job plan.

For many consultants, there will be a predictable amount of emergency work arising from on-call duties (operating lists, ward rounds, administration etc). The consultant and the employer should monitor the number of hours worked over the period of the rota and calculate the average number of PAs of emergency work done per week. Prospective cover should be factored into the calculation (see below).

Some emergency work will also be unpredictable and the same approach to calculating average weekly PAs spent in this type of activity should be taken. Diary evidence will be key to calculating the PA allocation fairly. Allocations for unpredictable on-call work should not exceed a maximum of two PAs per week. If unpredictable on-call work exceeds this level, this will be addressed through job planning. In exceptional circumstances, where the employer and the consultant agree that additional work beyond two PAs is necessary, this excess work will be recognised through additional arrangements locally.

The allocation of emergency PAs should be reviewed and adjusted as necessary at the annual job plan review, or whenever the consultant or the employer believes that emergency workload has changed.

Definitions of emergency work (as set out in the TCS):

Predictable emergency work: this is emergency work that takes place at regular and predictable times, often as a consequence of a period of on-call work (e.g. post-take ward rounds). This should be programmed into the working week as scheduled PAs.

Unpredictable emergency work: this is work done while on call and associated directly with the consultant's on-call duties (e.g. recall to hospital to operate on an emergency basis).

INFORMATION

TCS, paragraphs 4.10.1- 4.10.8

Cover for leave

in Scotland, prospective cover for annual leave and study leave is incorporated into the rota for on-call. Consultants are not expected to cover annual leave and study leave in the course of the normal working week.

If a consultant covers a colleagues on-call duties when they are away on study leave, annual leave and public holidays this prospective cover should be taken into account when assessing workload for both predictable and unpredictable emergency work. The frequency of on-call will reflect the prospective cover which means that for example a rota with 8 consultants will have a frequency of more than 1 in 8.

INFORMATION

TCS, paragraphs 7.7.1-7.7.2

Resident on call

Resident on call by consultants is an extremely expensive way of providing cover and the contract clearly states that consultants will not, save in exceptional circumstances, undertake resident on call. There is **no obligation** in the contract for them to do so. LNCs will have reached a local agreement with the employer on the arrangements that will apply to consultant resident on call, including remuneration, accommodation and catering. SCC believes that pay for resident on call should be substantially higher than standard or premium time rates.

INFORMATION

TCS, paragraph 4.9.1

Duty to be contactable

It is a requirement that while on call, the consultant must be contactable. However, it is possible for a consultant on level 2 availability supplement to agree with their employer not to be contactable immediately for short intervals, provided that there are arrangements for any messages to be taken and for the consultant to be able to respond immediately after the interval in question.

Private practice and on-call work

Private work should not be undertaken while on call and a consultant will have to make alternative arrangements to provide cover if emergency treatment for private patients regularly impacts on NHS commitments.

INFORMATION

TCS, paragraph 4.10.11

TCS, appendix 8, paragraphs 2.3-2.8

(EPA) Extra PAs

A consultant may agree with the employer to work more than the standard 10 PAs for a full-time consultant. There is no obligation on the consultant to work more than 10 PAs (but note the potential impact on pay progression below) and there is equally no obligation on the employer to offer more than 10 PAs. Where a consultant agrees to work extra PAs, these are payable at a rate of 10 per cent of FTE (full-time equivalent) basic pay, plus any discretionary points held.

A separate contract should be agreed with the employer for any extra PAs. This should set out what work is to be done in the extra PAs; this will mean that if the consultant or the employer decides to terminate the separate contract, it will be clear what work is to be dropped. LTFT consultants are also eligible for EPAs.

TCS, appendix 2, model contract for EPAs

Private practice and extra PAs

There is no obligation for a consultant to undertake PAs in excess of the standard 10 per week for a full-time consultant. However, one of the criteria for achieving progression through seniority points is that consultants should accept an extra paid PA in the NHS, if offered, before doing private work. See the private practice section for further details.

INFORMATION

TCS, section 4.4

Premium time/work done out of hours

The contract recognises work done at certain times of the week, defined as work undertaken outside of the hours of 8.00am to 8.00pm, Monday to Friday, and on public holidays, as 'premium time' or "out of hours work". Non-emergency work cannot be scheduled during these times without the agreement of the consultant and there should be no detriment to pay progression or any other matter if a consultant refuses to undertake non-emergency work in premium time.

An employer cannot require a consultant to undertake scheduled work outside 8.00am to 8.00pm, Monday to Friday and 9.00am to 1.00pm on Saturdays, or on public holidays. However, there are acute specialties where some "out of hours" work by consultants is necessary, so prospective appointees do need to be realistic about this possibility. If a doctor accepts a consultant post with scheduled work out of hours included in the agreed job plan (for example, on-site working overnight for three nights each month), then the doctor cannot unilaterally withdraw from undertaking this work since this would breach the contract.

The contract states that no more than 3 PAs per week should be out of hours other than in exceptional circumstances. During premium time the length of a PA is reduced to three hours (rather than four) or, by agreement, the rate of pay for a four-hour PA increases to 'time-and-a-third'.

INFORMATION

TCS, paragraphs 4.8.1-4.8.6

Location of work

It is generally expected that most PAs will be undertaken at the principal place of work as stated in the job plan and in the consultant's individual contract of employment. Arrangements to work off-site or at home for DCC/SPA may be agreed in relation to specific times and duties and should be clearly set out in the job plan. Recent developments in technology mean that there are now more options to vary the work location. Any change must be agreed via job planning.

INFORMATION

TCS, paragraphs 3.2.9-3.2.13

Travelling time

Travelling time to and from the principal place of work is not regarded as working time. Travelling time between the principal place of work and other work sites is working time and should be included within the category of work (e.g. DCC, SPA) for which the journey is necessary. Travel to and from work for NHS emergencies also counts as working time.

INFORMATION

TCS, paragraph 4.7.1

Workload assessment

Where a consultant believes that their average workload exceeds the amount of work for which the consultant has contracted as PAs agreed in the job plan, the consultant can request an interim job plan review, which the employer will set up within one month of the request.

In such cases, the consultant will complete a diary (you can use the BMA's [doctor diary app](#)) measuring workload over an agreed period. The completed diary, along with any other appropriate supporting documentation provided by the consultant and/or the employer, will form the basis of determining the consultant's workload. Where this demonstrates that workload does exceed contracted PAs, the job plan will be adjusted in one of the following ways:

- a) the consultant and employer may agree that the consultant will continue the same level of activity and contract for a number of extra PAs which equate to the hours worked; or
- b) the consultant and employer may agree a reduction in hours worked to equate to the number of PAs contracted in the previously agreed job plan; or
- c) the consultant and employer may agree a combination of a) and b) so that the PAs contracted in the revised agreed job plan (including any extra PAs) equate to the consultant's new working hours.

The employers will normally limit PAs to a maximum of 12.

Where it is agreed to contract for extra PAs as in a) above, the effective date for their payment will be the date on which the consultant first brought the matter to the employer's attention by requesting a job plan review. Where the employer agrees to reduce actual workload as in b) or c) above, this must be achieved within three months of the date of the job plan review.

If agreement cannot be reached, the mediation and appeals processes will apply.

Where an employer has concerns that the workload does not match the job plan, then they can ask the consultant to complete a diary or other supporting documentation, but if the consultant believes that this is an unreasonable request, then the consultant may refer back to the mediation and appeals processes.

INFORMATION

TCS, section 4.6

DL (2016) 14: Consultant Job Plan Review: Resolving Disagreements [https://www.sehd.scot.nhs.uk/dl/DL\(2016\)14.pdf](https://www.sehd.scot.nhs.uk/dl/DL(2016)14.pdf)

4

Pay

Pay points for consultants appointed on or after 1 April 2004

Consultants appointed on or after 1 April 2004 are appointed to the minimum point of the pay scale unless they have previously held a consultant post within the NHS or had consultant-level experience gained outside the NHS or they have participated in flexible training or undergone dual qualification. Progression through seniority points for consultants appointed on or after 1 April 2004 is on the anniversary of the first seniority date. Locum service can count towards determining the starting salary, seniority point and seniority date.

INFORMATION

TCS, sections 5 and 14

Pay progression

There are eight pay points on the salary scale. The value of the pay points is set out annually in a circular from the SGHSCD. The first five pay points are awarded at one-yearly intervals and the next three pay points are awarded at five-yearly intervals; in effect it is a 19-year pay scale.

It is explicitly stated in the TCS that it will be the norm for consultants to progress through the seniority points unless they have demonstrably failed in any one year to:

- Satisfactorily participate in the appraisal process, job planning and objective setting
- meet the time and service commitments in the job plan
- meet the personal objectives in the job plan
- work towards any agreed changes linked to the organisation's service objectives
- take up an extra paid PA (if offered) if they want to work privately
- meet the contract's private practice standards.

Employers cannot introduce any new criteria and pay progression cannot be withheld or delayed by factors out with the control of the consultant. There is a right of appeal against any decision to withhold pay progression set out in the TCS section 3. (TCS, section 3).

INFORMATION

TCS, section 5.2

TCS, section 3.4.1

Waiting times initiative payments

In circumstances where, as a direct result of published national or local waiting times targets, the employer requires increased ad hoc activity not previously identified within the job plan, then the consultant and the employer can agree a separate contract for this work. Such work is paid at three times the hourly rate appropriate to point 20 of the seniority scale, or alternatively, and by agreement with the employer:

- paid at twice the hourly rate appropriate to point 20 of the seniority scale set out in appendix 3 of the TCS and equivalent time off in lieu; or
- paid at the hourly rate appropriate to point 20 of the seniority scale set out in appendix 3 of the TCS and twice the equivalent time off in lieu.

INFORMATION

TCS, section 4.5

Fee-paying work (appendix 5 (a) work)

Fee-paying work (formerly called category 2 work) is work that is not part of a consultant's contractual work but is also not classed as private practice. It includes, for example, work required for life insurance purposes and work for the procurator fiscal.

An underlying principle of the contract is that consultants should not be paid twice for the work they do. A consultant undertaking fee-paying work can keep the fee due if they are doing the work in their own time i.e. not in NHS PA time, or if they 'time-shift' so that their NHS work is unaffected, or if the work is, by agreement, minimally disruptive to NHS activities. LNCs have in many areas reached agreements with employers on a definition of 'minimally disruptive'.

INFORMATION

TCS, section 4.3

Fees for NHS work (section 9/appendix 5 (b) work)

Fees for NHS work, which covers domiciliary consultations, exceptional consultations, lecture fees, completion of assessment and certificate under section 47 of the Adults with Incapacity (Scotland) Act 2000, membership of consultant appointment committees and medical services to local authorities, may only be claimed if the work is undertaken outwith agreed programmed activities. Family planning is treated within the TCS as contracted work to be carried out within PAs, comprising an element of DCC work. Consultants on the 2004 contract cannot claim fees for family planning work.

INFORMATION

TCS, section 9

[NHS Circular PCS \(DD\) 2005/13](#): Amendments to the TCS for the 2004 consultant contract in respect of family planning fees

Relationship between private practice, NHS work and fee-paying work

The contract clarifies the relationship between NHS work, private work and fee-paying work. The provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services and, with the exception of the need to provide emergency care, agreed NHS commitments take precedence over private work. This relationship is set out clearly in section 6 of the TCS and in the *Code of conduct for private practice* set out in Appendix 8 (see section on private practice for more information).

This Code has been slightly amended as a consequence of the publication of revised guidance on the arrangements for NHS patients receiving private healthcare in addition to NHS care. It allows patients to access both NHS and private care for one condition during a single visit to an NHS organisation by the removal of the first bullet point of paragraph 2.13 of the Code of Conduct.

INFORMATION

TCS, sections 4.3, 4.5 and 9

Code of Conduct for Private Practice: Recommended Standards for NHS Consultants – TCS, appendix 8

[SGHSCD/CMO \(2009\) 3](#) Guidance on the possible combination of elements of NHS and private care for individual patients

[PCS \(DD\) 2009/1](#) Change to Code of Conduct for Private Practice: recommended standards of practice for NHS consultants

Recruitment and retention allowances

To date, NHSScotland employers have agreed to operate a moratorium on the use of these premia.

INFORMATION

TCS, section 5.3

Directors of public health supplements

Directors of public health are entitled to banded supplements (B-D and Island Health Boards) in addition to basic salary, as set out annually in SGHSCD circulars. Eligibility for each band depends upon the population served by the post and the weight of the post.

INFORMATION

TCS, section 2.4

Additional responsibility payments

The TCS allows discretion for employers to pay additional responsibility payments. This provision can be used to pay consultants for any additional responsibilities, such as being a clinical director. Where such activities are remunerated, this will be by contracting for extra PAs or by additional remuneration agreed locally, or a combination of both. It is also possible to substitute the time for other activities.

Consultants are advised to contact BMA Pensions if they have any queries about whether such payments should be pensionable.

INFORMATION

TCS, paragraph 4.2.6

Less than full time (LTFT) contracts

Employers can offer less than full time consultant contracts of between one and nine PAs per week. The working pattern would be agreed through job planning.

INFORMATION

TCS, paragraphs 4.1.5 and 14.3.5

Locum appointments

Locum consultants are employed to provide cover for temporary vacancies and various types of leave. The length of appointments can vary from a few weeks to several months. The guidance on locum appointments states that they should be short term only, although it may not be possible to determine the duration of the appointment at the outset.

Where a locum appointment extends beyond three months, the situation should be reviewed, and again at three-monthly intervals thereafter, and this requirement should be included in any appointment letter. The guidance is that locum consultant appointments should be limited to a maximum period of one year.

Locums have no automatic entitlement to be appointed to the substantive post when it is filled, because all consultant appointments are subject to the statutory consultant appointment procedures. Except for the differences detailed below, all sections of the TCS apply to locum appointments.

Basic salary

Locums who have never held a substantive NHS consultant post are paid at the first pay point of the salary scale, unless they have gained consultant level experience outside the NHS, in which case this should be taken into account when agreeing starting salary.

Locums who hold a substantive consultant post (either with the same employer or with another NHS employer) and will continue to do so once the locum post comes to an end are paid at their existing pay point.

Locums who do not currently hold a substantive consultant post but who have held one in the past (e.g. retired consultants) are paid the equivalent of their most recent pay point (excluding distinction awards, discretionary points and clinical excellence awards) or, if they have not previously been employed under the 2004 contract, the rate of pay consistent with their calculated seniority.

The provisions of paragraph 5.1.7 now apply when determining the starting salary for those taking up locum consultant appointments: "Where the salary of the previous regular appointment, including SAS staff grade optional and associate specialist discretionary points, exceeds the minimum of the consultant salary scale, the consultant will be appointed to a point on the scale next above the pay rate of their previous regular appointment."

[\(PCS\(DD\)2013/3\)](#)

Pay progression

When 12 months' locum service has been completed (continuous or cumulative), the employer should assess whether the criteria for pay progression have been met. If part of the previous 12 months' service has been for one or more other NHS employers, the current employer should seek assurance from previous employers as to whether the criteria have been fulfilled.

Job planning

A locum consultant is appointed on the basis of agreeing to fulfil the existing job plan for the post subject to any modifications which the employer may ask him/her to agree in order to accommodate the level of contribution required of a locum consultant, where that may be different to the contribution agreed for a substantive consultant. This job plan is open to review in line with the provisions for substantive consultant posts. Objectives should be agreed as part of the job planning process and locums should have the same access to resources e.g. for administrative support and continuing professional development, as other consultants.

INFORMATION

TCS, section 11

[Code of practice](#) in the appointment and employment of locum doctors

Mediation and appeals processes

If there is a dispute over a job plan or a decision relating to pay progression, there is a process of mediation and appeal that can be followed.

SCC and the NHS Scotland Management Steering Group have agreed joint guidance about resolving disagreements with the job plan review process. This does not seek to undermine or replace those TCS provisions in any way. This guidance is an attempt to ensure that processes relate to the current NHS in Scotland, without undermining the overall approach specified in the TCS. It also suggests a more mediated and less adversarial approach, which should help resolve disagreements at an earlier stage in the process:

INFORMATION

TCS, section 3.4

[Joint guidance by SCC and MSG on job planning and review process – DL\(2016\)14](#)

Transferring to the 2004 contract from the old contract

Consultants in post prior to 1 April 2004 who are still on the pre-2004 contract have the option to transfer to the 2004 contract or retain their existing terms.

INFORMATION

TCS, section 14

5

Job planning

A job plan is a detailed description of the duties and responsibilities of a consultant and of the supporting resources available to carry them out. The job planning process is based on a partnership approach between consultants and medical managers and a contractual obligation for both parties.

TCS, section 3

[BMA guidance on Job Planning for New Consultants and on managing the job planning review joint guidance by SCC and MSG on job planning and review process – DL\(2016\)14](#)

The purpose of job planning

The job planning process is a prospective process that needs to be based on a partnership approach to enable consultants and employers to:

- effectively prioritise work and avoid excessive consultant workload
- agree how a consultant or consultant team can most effectively support the wider objectives of the service and meet the needs of patients
- agree how the NHS employer can best support a consultant in delivering these responsibilities
- provide the consultant with evidence for appraisal
- comply with the Working Time Regulations
- agree activity above the standard commitment via prospectively agreed extra programmed activities (EPAs).

Job planning can therefore be of great benefit and all consultants should adequately prepare for, and participate actively in, job planning on an annual basis, especially as participation in the process will be a factor in informing pay progression.

The process of job planning

The TCS are clear that the job plan is agreed between the consultant and the employer. The employer is normally represented by the medical director/director of public health/clinical director or other lead clinician nominated by the medical director or DPH. A nonmedical manager can only be present at a job planning meeting with the agreement of the consultant.

The consultant has a key role in the job plan review and should consider the following in advance of the meeting:

- what is currently in the job plan
- what work is actually undertaken, especially if it differs from what is agreed in the job plan. If the work changes then there should be a review of the job plan and agreement reached on the change
- the types of work contained within the job plan (e.g. DCC, SPA, external duties or additional responsibilities)
- any changes the consultant would like to see in the job plan
- diary evidence if the current workload exceeds the time allocated in the job plan

The consultant and the medical manager should then discuss all elements of the current and future responsibilities and use best endeavours to agree the job plan. Where agreement cannot be reached a further meeting may be indicated and if the disagreement continues then either party can instigate the first stage of the mediation and appeals processes.

any boards have implemented a job planning systems such as Allocate or Zircadian and should remember that these systems are for recording the agreement following the job planning discussions as specified in the TCS. They are not a substitute for the annual job plan review.

6

Format of job plans

National model

There is an agreed national model of a job plan contained in appendix 4 of the TCS. For boards using Ejob planning the format varies.

Job plan content

The job plan will detail the consultant's commitment to the NHS. It will set out:

- a timetable of activities such as out-patient clinics, ward rounds and operating sessions, which have a specific location and time
- activities which are not undertaken at specific locations or times
- activities during premium rate hours of work
- a summary of the total number of hours of each type of activity in the timetable
- the availability supplement which is based on frequency and level.
- any arrangements for extra PAs, to be covered by a separate contract and schedule
- a list of agreed objectives, with resources required (see below)
- the consultant's accountability arrangements.

Some of these issues have been covered in detail in the previous section. Where this is not the case, further information is outlined below.

Objectives

Objectives are a contractual obligation for consultants. Objectives could relate to activity and efficiency, clinical outcomes, clinical standards, local service objectives or management of resources. They may flow from discussions and agreement at the annual appraisal. Consultants will need to make every reasonable effort to meet these objectives to achieve pay progression and so they must be appropriate, achievable, identified and, most importantly, agreed between the consultant and employer. It is not reasonable to set objectives where there are significant influencing factors outside the consultant's control e.g. waiting time targets. Consultants have no obligation to sign up to objectives that are unreasonable.

INFORMATION

TCS, section 3, paragraphs 3.2.16-3.2.21

Fee-paying work

The TCS operate on the general principle that consultants are entitled to receive fees for work done in their own time but should not receive extra fees for work done during NHS PAs i.e. not be paid twice for the same work. However, there is scope for consultants to retain fees for work done in their PAs where there is 'minimal disruption to NHS work'. Alternatively, consultants can agree to ensure that their NHS work is made up at another time – effectively time shifting their work. Another option is to negotiate that the work is part of the working week, and through the job planning process, negotiate an allocation in terms of PAs.

It is open to LNCs to reach agreements with employers on how this work will be treated.

All family planning work by consultants on the 2004 contract is undertaken as part of their agreed PAs and there is no fee-paying option. Individuals who hold religious or moral objections to carrying out family planning work may declare such objections on appointment, or at any point at which they may be asked to commence such work, in which case they will be excused from undertaking such duties.

INFORMATION

TCS, section 9, paragraph 9.4.1 [PCS \(DD\) 2005/13](#)

Private practice

The job plan should include details of any private work undertaken by the consultant. This is a contractual requirement under the 2004 contract. Consultants should identify any regular private commitments and provide information on the planned location, timing and the broad type of work that is being undertaken. The employer has no right to ask for financial details relating to private practice. Details are covered in the code of conduct for private practice, contained in appendix 8 of the TCS.

INFORMATION

TCS, section 6 and appendix 8

Supporting resources

The job plan should identify and agree the resources that the consultant needs to do the job properly. This gives the opportunity to make sure that the employer is formally aware of the supporting resources required, for example secretarial support, medical staff support and multidisciplinary team support, office space, equipment and information technology. A lack of appropriate supporting resources could have an impact upon consultants meeting their objectives. It is therefore essential that the required resources are identified when job plans are agreed. Pay progression cannot be withheld if consultants have not met objectives for reasons beyond their control.

INFORMATION

TCS, paragraph 3.2.2

7

Job plan review

Annual review

It is a contractual obligation for all consultants to have an annual job plan review. The review should consider progress against objectives and factors affecting the achievement of objectives; adequacy of resources; potential changes to duties or responsibilities; ways to improve workload management and planning of careers.

Following the review, the medical manager will complete documentation to confirm progression through the seniority points.

Interim review

The consultant or employer is entitled to request an interim review if changes to staffing resources, or working practices or the consultant's circumstances, requires it. The contract also provides for an interim job plan review to be carried out where a consultant believes that the average workload exceeds the amount of work for which the consultant has contracted as PAs agreed in the job plan.

SSASC and SCC have agreed the following joint statement with MSG regarding SPA time for appraisers:

"BMA Scotland and MSG recognise that career grade doctors working for NHSScotland are required to have an annual appraisal. Therefore, it is important that consultants and SAS doctors who have undergone appraiser training have sufficient time in their job plans to fulfil their appraiser role effectively. When a consultant or an SAS doctor becomes a trained appraiser, a job plan review will normally be appropriate, to ensure that the role is planned into their agreed work schedule."

If there is a disagreement/dispute about the job plan, the mediation and appeals processes should be used.

INFORMATION

TCS, section 3.3 and 4.6

[CEL \(2007\)2](#) Recommended documentation for seniority progression within the consultant contract

[CEL \(2012\) 31](#) Medical revalidation: annual appraisal documentation

Specialty specific job plan guidance

Specific guidance on job plans for the following specialties is available on the BMA website: Anaesthesia and pain management, Chemical pathology, Community paediatrics, Diagnostic radiology, Emergency medicine, Genito-Urinary medicine, Histopathology, Medical specialties, Microbiology, Obstetrics and gynaecology, Oral and maxillo facial surgery, Orthodontics, Paediatric dentistry, Pain management, and Restorative dentistry. This guidance has been produced for England only, and the contractual arrangements are different in some respects in Scotland. However, the guidance does provide useful information.

INFORMATION

TCS, section 3

8

Other terms and conditions of service (TCS) issues

Pay

The Doctors and Dentists Review Body (DDRB) reports each year to the First Minister and the Cabinet Secretary for Health and Wellbeing of the Scottish Government (and to the relevant ministers in England, Northern Ireland and Wales), usually in January or February. The report is made public several weeks later, for implementation on 1 April of the same year. In recent years this has been published later in the year. Each year the health departments, employers' organisations and the BMA present written evidence to the DDRB stating their case on appropriate remuneration for the forthcoming year, and this is supplemented by oral evidence in November.

The DDRB recommends salary increases for consultants and other doctors and recommends the value of discretionary points. The government will then make a decision on the DDRB recommendations; when the increases are implemented, they are issued in the form of a circular from the SGHSCD and incorporated into the national Terms and Conditions of Service for the Consultant Grade (Scotland).

INFORMATION

[Current pay scales](#)

[Doctors' pay BMA Guidance Note](#)

References are made throughout this section to paragraphs in the General Whitley Council handbook. Since the introduction of the agenda for change pay arrangements for non-medical staff in the NHS, the GWC has been replaced by an NHS staff council. As a result, some sections of the GWC handbook have been replaced by updated terms and conditions but there are some which continue to apply to consultants.

For some of the policies listed in appendix 10 of the GWC the current arrangements for all staff in NHS Scotland are detailed in either Partnership Information Network (PIN) policies or Once for Scotland policies

Expenses and allowances **Travel expenses**

Consultants required to travel on NHS business are entitled to claim reimbursement of travelling expenses. This will be either the cost of public transport or a mileage allowance. It should be noted that part of the mileage allowance is taxable. Possession and use of a motor car is rarely a contractual requirement even for community-based staff. Consultants may be offered a crown or lease car.

Lease or crown cars

The crown car scheme for hospital doctors was introduced in 1990. In the 2004 contract, reference is made to lease cars as opposed to crown cars. The details around this are in the TCS 8.2.28.

Mileage allowances for consultants not offered lease cars

Consultants not offered lease cars who are required to use their own car on NHS business, are entitled to allowances at the standard rate unless they are classified as regular users. Standard and regular user mileage rates vary according to engine capacity.

The mileage rate paid to regular users is lower than the standard rate, but regular users are also paid a lump sum in equal monthly instalments regardless of the mileage covered.

Consultants who fulfil any of the following criteria are paid at regular user rates:

- travel an average of more than 3,500 miles a year on official business; or
- travel on average at least 1,250 miles a year on official business; and
 - i) necessarily use their cars an average of three days a week; or
 - ii) spend an average of at least 50 per cent of their time in travelling in the course of NHS business (this time to include the duties performed during the visits)
- are classified as 'essential users' because they fulfil the following criteria:
 - travel on average at least 1,250 miles (other than normal travel between home or private practice premises and principal hospital) each year; and
 - have ultimate clinical responsibility, or on-call responsibility normally controlled by a rota system, for the diagnosis and treatment of patients in hospital with emergency conditions which require them to be immediately available for recall; and iii) are expected to be recalled to hospital in an emergency at an average rate of twice or more during a working week, the rate of emergency call out being averaged over the year but excluding periods of leave.

Classification as an essential user only results in access to the regular user category and has no other effect.

Mileage allowances for consultants who refuse a lease or crown car

Special provisions apply to those who refuse a lease or crown car.

Public transport rate

The public transport rate is payable when consultants use their private cars when travel by public transport would be more appropriate.

Official journeys

The journeys listed below are classified as official business and mileage allowance may be claimed:

- Principal hospital (i.e. the hospital where the consultant's principal duties lie) and return to any destination, and travel between destinations, on official business.
- Home to any destination other than the principal hospital and return, on official business, subject to a maximum of the distance from the principal hospital to the place visited plus 10 miles in each direction or the actual mileage, whichever is the less.
- Home to principal hospital and return when the consultant is called out in an emergency.
- Home to principal hospital and return, subject to a maximum of 10 miles in each direction, when consultants use their cars for subsequent official journeys, or where there is an acknowledged extensive liability to make emergency domiciliary visits.

INFORMATION

TCS, section 8

<https://www.bma.org.uk/advice/employment/fees>

[NHS Circular 1990 \(PCS\) 27](#) Personal Transport Arrangements

[NHS Circular PCS \(DD\) 2001/4](#) as amended by [PCS \(DD\) 2006/6](#) (Clarification of the circumstances in which the payment of standard mileage rate and public transport rate is appropriate) and [PCS \(DD\) 2008/05](#) (changes to NHS Scotland mileage rates)

Removal expenses

The provisions of the GWC Conditions of Service apply to consultants' removal expenses. There is an entitlement to receive reimbursement in certain circumstances, for example, if a consultant is required to move by the employer, but significant discretion is left to employers. Employers determine the scope and level of financial assistance to be offered to the prospective employee prior to the post being accepted.

Consultants need to be aware that expenses offered may vary, although the GWC scheme does indicate that expenses should be based on costs actually incurred.

The LNC for the NHS board should be involved in agreeing the removal expenses package and consultants should ensure that they are aware of the level of assistance which will be provided, the aspects of removal costs which will be reimbursed, and the upper limit of payment in normal circumstances before accepting a post. Advice should be sought on what is actually covered by the local scheme and not just the amounts reimbursed. In particular, consultants should note that employers may require that removal expenses are repaid in full or in part if they move to another employer within a certain period of time. The extent to which the expenses must be repaid under these circumstances is at the employer's discretion and may be dependent on the length of employment. Additionally, removal expenses in excess of a certain amount are taxable, and many employers set upper limits on the expenses payable in line with the tax threshold (currently £8,000). A copy of the employer's removal expenses policy and the time frame for claiming should be available from the employer.

Before accepting an appointment, consultants who have to move to take up that appointment should contact the new employer as early as possible to ascertain whether or not they are eligible for removal expenses. It is important that any negotiation of removal expenses takes place before the post is accepted. Only the first £8000 of reimbursement of removal expenses is tax-free. Confirmation of any agreement with an employer should be obtained in writing.

INFORMATION

TCS, paragraph 8.6.1

GWC Conditions of Service, section 26

[BMA Guidance](#): Removal and associated expenses for NHS medical staff

Telephones

Provision of telephones

It is normally a contractual requirement for consultants to be contactable by telephone. Employers should pay for the cost of installation and rental of telephones where it is essential for the efficiency of the service that the consultant should be on call outside normal working hours and the telephone is the only practicable method of communication with the consultant. In most cases the payment by employers of installation and rental costs is taxable.

Official business calls

Consultants may claim the cost of outgoing calls made on official business from the employer.

Mobile phones

Consultants should be able to negotiate with the employer the provision of a mobile phone or pager and/or subsequent outgoing NHS business calls where this is needed for work purposes. Where there is no clear employer agreement on mobile phones, the issue should be raised with the LNC to produce clear guidance for consultants.

INFORMATION

[NHS Circular 1979 \(PCS\) 32](#) Provision of Telephones for Medical and Dental Staff

Subsistence allowances

When consultants are required to be away from their main or regular place of work on employer's business, they may claim subsistence allowances in accordance with the GWC Conditions of Service. Subsistence allowances, which are payable in addition to travelling expenses, can be claimed for approved overnight stays, daytime meals and late-night duties expenses. Situations where subsistence allowances may be payable include during periods of approved study leave and, at the discretion of the prospective employer, during a search for suitable permanent accommodation in a new area as part of removal expenses. Reimbursement should be claimed only for the expenses which consultants have actually incurred, up to a maximum of the appropriate allowance. Vouchers or receipts are required. Where the subsistence allowances have been exceeded, reimbursement of the excess costs is discretionary. Consultants are normally required to submit claims at intervals of not more than three months after the end of the period to which the claim relates. Consultants are advised to check whether GWC arrangements apply locally since some employers may have updated these arrangements. In any event, consultants are advised to check their entitlement before incurring expenditure.

INFORMATION

TCS, paragraph 8.3.1
GWC Conditions of Service, section 22

Annual leave

Consultants are entitled to 6.6 weeks' annual leave per year. The leave year runs from the date of taking up appointment as a consultant.

The calculation of annual leave when taken in periods of less than a week is currently (June 2022) under discussion between BMA and employers.

Consultants with substantive contracts may carry forward up to five days of leave not taken in a leave year into the next leave year, subject to the needs of the service. Consultants must request annual leave in line with locally agreed policies and the granting of such leave is subject to management approval. It may be helpful to administer annual leave arrangements within clinical directorates. General Whitley Council states that where employees are prevented by their employing authority from taking the full allowance of annual leave before the end of the leave year, they shall be allowed to make up the deficiency during the ensuing leave year at a time to be mutually agreed.

Public holidays

Until recently consultants were entitled to 10 public holidays. In 2021 the BMA reached agreement with the Scottish Government and NHS Employers to allow the substitution of two public holidays with three additional annual leave days on a permanent basis for all secondary care doctors. This means that all consultants now have 8 public holidays per year. LTFT consultants have a pro rata allocation of public holidays.

DL Annual leave and public holiday entitlements

Consultants who are required to be on call on a public holiday will receive a day off in lieu. Consultants who are required to be present in the hospital/other place of work, or undertake complex telephone consultations, between the hours of midnight and 9am on a public holiday will receive a day off in lieu. Work undertaken on public holidays will be paid at premium rates.

INFORMATION

TCS, section 7.1
GWC Conditions of Service, section 1
TCS section 7.2
TCS section 4.8
Annual leave and public holiday entitlements: [PCS2021 \(DD\)01](#)

Study and professional leave

Consultants' study leave is mainly used to enable them to participate in continuing professional development (CPD). It therefore plays an important role in ensuring the highest standard of patient care, and consultants should be encouraged to take such leave. It is stated in the TCS that consultants should receive study leave with pay and expenses in the UK and EU/EEA, with a maximum of 30 days in a period of three years. Employers may, at their discretion, grant study leave above the periods recommended with or without pay and expenses.

The day-to-day administration of study leave rests with the employer, and there are considerable variations between employers in the way that study leave applications are dealt with.

Every consultant is required by their royal college to attend CPD courses which help to maintain an acceptable standard of clinical skill. Under the GMC's 'Duties of a Doctor', consultants have a clear responsibility to keep up to date with current best practice. The royal colleges have highly developed programmes on CPD, and colleges can provide details of the current CPD requirements in individual specialties.

There are a number of factors to be taken into account when considering study leave applications:

- once a study leave application within the UK is accepted, full reimbursement of associated expenses will be made
- where leave is taken elsewhere within the European Union/European Economic Area, it will be granted with reimbursement of associated expenses at a level agreed between the consultant and the employer, which will normally be comparable with the level of expenses available for study leave within the UK
- the right of a consultant to take study leave should not depend on the employer's financial position
- employers should not turn down study leave applications on financial grounds
- study leave should not be used for inappropriate purposes, for example attending consultant appointment committees.

INFORMATION

TCS, section 7.3

[SHM 29/1967](#); [SHM 41/1968](#); DS (MD) 7/1973; [DS \(78\) 50](#); SOHHD/DGM (1991) 64 – all SGHSCD circulars concerning study leave

Sick leave

The following information is based on the provisions of the TCS and GWC conditions.

Procedure to be followed

Consultants should inform their employer immediately according to local arrangements if they are unable to work because of illness. If the illness lasts longer than three calendar days, a self-certificate must be submitted within the first seven days of absence. Further statements in the form of a medical certificate provided by another doctor must be submitted for any absence extending beyond the first seven calendar days. These further statements will not normally be submitted more frequently than once every seven days, although the employer is entitled to ask for more frequent statements. The employer may also require a consultant who is unable to perform his/her duties as a consequence of illness to submit to an examination by a medical practitioner nominated by the employer.

Hospital admission

Consultants admitted to hospital must submit a doctor's statement on admission and discharge, or a self-certificate if absent for seven days or less.

Allowances

An allowance is paid during sick leave on a sliding scale according to length of service, with a minimum of one month's full pay and a maximum of six months' full pay and six months' half pay, although the employer has discretion to extend the application of the scale in exceptional cases. Most consultants are entitled by their previous service to the maximum allowance. The calculation takes account of any sick leave already taken in the 12 months immediately prior to the first day of absence. The allowances are calculated as if the consultant is at work, ie includes availability supplement and any management allowances payable, discretionary points etc.

Exclusions

An allowance is not normally paid in the following cases:

- accident due to active participation in sport as a professional
- contributory negligence
- once employment is terminated, for example because of permanent ill health, resignation, or any other reason
- failure to observe the conditions of the scheme
- conduct prejudicial to recovery.

INFORMATION

TCS, section 7.5

GWC Conditions of Service, sections 1, 57 and 61

[NHS Circular 1983 \(PCS\) 11](#) – Introduction of Statutory Sick Pay

[CEL 17 \(2009\)](#) – Carry Over of Holiday Entitlement during Long Term Sick Leave

Income during sick leave

The allowance paid by the employer during absence on sick leave must not result in consultants receiving more than their normal salary for the period. In practice, many employers pay the consultant as normal and make separate arrangements to claim back the statutory sick pay from HM Revenue and Customs (HMRC), stating this element on the pay slip. Special arrangements for pay and sick leave entitlement exist in the case of a consultant receiving damages from a third party after an accident. Further advice is available from the BMA.

Private practice during sick leave

Consultants should be extremely cautious during sick leave with regard to the other activities they normally carry out. Most employers may regard the undertaking of private practice during sick leave as a serious disciplinary offence. Consultants should always check with their employer and get confirmation in writing before undertaking work while on sick leave and should seek advice from the BMA.

Illness during annual leave

Consultants who fall ill during annual leave and produce a statement to that effect are regarded as being on sick leave from the date of the statement and paid accordingly. The annual leave may then be taken at a later date. This does not apply if the consultant falls ill on a public holiday.

Help and advice for sick doctors

Details of services offering help and advice to sick doctors can be found in the section on health issues.

Special leave

Special leave with or without pay may be granted at the discretion of the employer with the following qualifications:

- jury service: normally consultants are entitled to be excused jury service
- contact with notifiable diseases: in general, the situation will not arise in the case of consultants who come into contact with notifiable diseases because of their professional position.

Leave for attendance as an expert witness

Leave for consultants attending court as expert witnesses is a contentious area, with some employers taking the view that this should be categorised as fee paying work, and consequently special leave with pay may be refused. However, it is arguable that it would be unreasonable for employers to object to consultants carrying out this work since it is part of the judicial process of the state. Consultants are entitled to time off with pay to attend court as professional witnesses, in connection with their own patients.

Leave for trade union duties and activities

The Trade Union and Labour Relations (Consolidation) Act 1992 places an obligation on employers to allow officials of recognised trade unions, which would include BMA local and national representatives and accredited members of BMA LNCs, to take reasonable time off with pay to undertake trade union duties during working hours. Under the Act, 'duties would be taken to refer to circumstances where an individual would be acting as a representative of the profession, either locally or nationally'.

The Act also requires an employer to allow members of recognised trade unions to take reasonable time off, not necessarily with pay, for the purpose of taking part in trade union activity, such as BMA meetings.

The way in which these matters should work in practice locally will be defined in local facilities agreements agreed by Health Boards with Trades Unions and Professional Associations, including the BMA. Trade union activity should be recorded in the job plan as External Duty time.

INFORMATION

TCS, section 7.6

GWC Conditions of Service, sections 12 and 38

[ACAS Code of Practice 3](#) – Time off for Trade Union Duties and Activities Trade Union and Labour Relations (Consolidation) Act 1992, sections 168-73 PIN Guideline:

[Facilities Arrangements](#)

Sabbatical leave

Under the contract, consultants are eligible, after seven years' service as a consultant, to apply for one period of sabbatical leave of up to six weeks or, after 10 years' service, for up to three months' sabbatical leave. If either of these options is granted with pay, then no further period of paid sabbatical leave will be granted until retirement. The following provisions also apply:

- approved arrangements must be made to cover the absence on sabbatical
- the consultant must make a stated case explaining how the leave will be used and will benefit the NHS, which must have the written support of the clinical director/manager
- the employer has discretion as to whether to meet any travel and accommodation expenses in part or in full
- if sabbatical leave has been granted without pay, the employer has discretion to grant additional leave at intervals of no less than seven years after the first period.

INFORMATION

TCS, section 7.4

Employment break scheme

NHS employers should provide all staff with access to an employment break scheme. The scheme should be agreed between employers and local staff representatives. The scheme should be viewed with others, particularly those relating to flexible working, balancing work and personal life, and provisions for carers, as part of the commitment to arrangements which enable employees to balance paid work with their other commitments and responsibilities.

INFORMATION

TCS, Appendix 12 [PCS\(DD\)2013/3](#):

[Supporting The Work-Life Balance](#) PIN Policy

Leave and pay for new parents

Consultants, like other employees, have certain minimum statutory rights to maternity and parental (including paternity) leave and pay. In addition, under the NHS conditions of service, which have been incorporated into the TCS for consultants, consultants can take advantage of more beneficial occupational arrangements for maternity leave and pay.

Entitlements under both the statutory and NHS Staff schemes depend on certain qualifying conditions, and the application of, and interrelationship between, the schemes, is a complicated area and the BMA Guidance provides more detail.

Under the current NHS Staff maternity leave scheme, consultants must have normally had 12 months' service with one or more NHS employers, with no break in service of more than three calendar months, at the beginning of the 11th week before the expected week of childbirth to qualify for maternity leave and pay. Notice of intention to return to work must be given in writing at least 8 weeks before the return date. Failure to return to work for the same or another NHS employer for a minimum period of three months may result in liability to repay some or all of the maternity pay.

The maximum entitlement to leave is 52 weeks (including paid and unpaid). Maternity leave with pay consists of 26 weeks' pay made up of eight weeks at full pay (less any statutory maternity pay (SMP) or maternity allowance (MA), including any dependents' allowances receivable) and 18 weeks at half of full pay (plus any SMP or MA, including any dependents' allowances receivable), providing the total does not exceed full pay. By prior agreement with the employer, occupational maternity pay may be paid in a different way, for example, a combination of full pay and half pay, or a fixed amount spread equally over the maternity leave period. All employees are entitled to a further 26 weeks' maternity leave, the first 13 of which have an entitlement to SMP. The scheme also covers areas including health and safety of employees pre and post birth, return to flexible working arrangements and contractual entitlements during maternity leave. Adoption arrangements for the main carer mirror the maternity leave provisions.

Paternity leave and pay is available to employees following the birth of a child or placement of a child for adoption. Following the birth of a child, the partner of the primary carer is entitled to occupational paternity leave and pay. Shared parental leave and pay can be taken at any time within one year from the birth or placement for adoption, providing two weeks' compulsory maternity or adoption leave has been taken first. There are separate arrangements for parental leave, which can be taken any time up to the child's 18th birthday.

TCS, paragraph 7.6.2 and appendix 16 Maternity and Parental Leave Regulations 1999

[BMA guidance](#): Working parents [PCS\(DD\)2013/3](#):

[PCS\(DD\)2020/01](#): Leave and Pay for New Parents [PCS\(DD\)2020/01](#): Child bereavement leave

Injury allowance

Changes have been made to the NHS Injury Benefit Scheme. Historically this scheme provided for the payment of either a Temporary Injury Allowance (TIA) or a Permanent Injury Benefit (PIB) where injury or illness occurred as a result of NHS employment.

The NHS Staff Council has approved a new section in the NHS Terms and Conditions of Service Handbook (Section 22) which introduces a contractual right to injury allowance which replaces the statutory Injury Benefit provisions. The new contractual injury allowance arrangements apply to all doctors and dentists employed by NHS Boards, Special Health Boards and NHS National Services Scotland.

INFORMATION

PCS(DD)2013/3

Medical indemnity

The NHS provides medical indemnity for its staff via the NHS indemnity scheme. The scheme ensures that employers bear the financial costs arising from claims for negligence against staff carrying out work which falls under their contract. Along with other NHS employed doctors, consultants are covered by NHS indemnity for the work they undertake under their NHS contracts. If a consultant is treating NHS patients under a contract with their employer (whether that is the main contract of employment or a separate contract issued specifically for dealing with waiting list patients), the consultant is covered by NHS indemnity.

The NHS indemnity scheme covers:

- work under NHS contracts including in non-NHS locations
- hospital doctor locum work, whether through a locum agency or directly with the employer
- domiciliary visits.

The NHS indemnity scheme does not necessarily cover:

- private practice work
- fee-paying work i.e. reports for a third party where a fee may be charged
- ‘good Samaritan’ work, such as assisting at a traffic accident
- costs in GMC proceedings
- inter-hospital transfer.

Consultants should ensure in each case that the work is covered either by NHS indemnity or by another employer or by their defence body, taking out additional cover if necessary.

Under the NHS indemnity scheme, employers, being financially liable for the medical negligence of their staff, have the ultimate right to decide how the defence of any case is handled. Subject to this, doctors may be represented separately at their own cost in any case of alleged negligence. However, they are then liable for any additional expenses of an employer if they elect to be separately defended. If doctors unreasonably fail to cooperate fully in the defence of the claim or action against the employer, the employer may, at its discretion, seek to recover part or all of any liability which it may incur.

The Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) is a risk transfer and financing scheme for NHSScotland, which has been developed by the SGHSCD in partnership with Willis Ltd, the appointed scheme manager. Its primary objective is to provide cost-effective risk pooling and claims management arrangements for Scotland’s NHS boards and special health boards.

The BMA advises that it is essential that all consultants retain some form of personal indemnity insurance to cover any non-NHS work, as well as NHS indemnity cover. Consultants should consult the defence bodies to determine the degree of cover required and the schemes available.

INFORMATION

[MEL \(2000\) 18](#) – Clinical Negligence and Other Risks Indemnity Scheme

[HDL \(2005\) 12](#) – paragraph 11 regarding WLI (Waiting List Initiative) work at the Golden Jubilee National Hospital

[BMA Members Guidance](#): NHS indemnity

Grievance procedure

Employers are required to follow the provisions of the once for Scotland grievance policy which enables employees to challenge an employer's decision which may adversely affect their terms and conditions of service. The once for Scotland grievance procedure is designed to provide a speedy resolution of the grievance as close as possible to the source.

INFORMATION

NHS Scotland Grievance Policy <https://workforce.nhs.scot/policies/grievance-policy-overview/>

ACAS Code of Practice 1 – Disciplinary and Grievance Procedures <http://www.acas.org.uk/index.aspx?articleid=2174>

Notice of termination of employment

If the employer terminates the contract, three months' notice in writing must be given to the consultant. Likewise, consultants wishing to terminate their employment must also give the employer three months' notice. A notice period of less than three months may only be given with the express agreement of the other party save in circumstances of summary dismissal on grounds of gross misconduct or resignation on grounds of constructive dismissal.

INFORMATION

TCS, section 10.5

Local contractual variations

NHS Boards must comply with the statutory position in relation to their powers to employ staff. This means that, where pay and conditions of service for a class of NHS staff have been agreed in negotiations and approved or authorised by Scottish ministers, boards must employ such staff on those terms and conditions.

Where boards want to employ staff on non-approved terms and conditions, for example, for recruitment and retention purposes, then they can apply to Scottish ministers for an order allowing a variation. Subject to any variation order which might be granted by ministers, all staff must be employed on nationally approved terms, pay and conditions.

9

Revalidation

Revalidation is the process for doctors to positively affirm to the General Medical Council (GMC) that they are up to date and fit to practise. It applies to all licensed doctors in the UK working in the NHS and the private sector and all branches of practice. Doctors will need to meet the standards set by the GMC, taking into account guidance for their specialty, to maintain their license to practice (since 2009 all doctors on the medical register who wish to practise medicine have been required to have a Licence to Practise).

It represents a way of regulating the medical profession that will provide a focus for doctors' efforts to maintain and improve their practice; facilitate the organisations in which doctors' work to support them in keeping their practice up to date; and encourage patients and the public to provide feedback about the medical care they receive from doctors.

Revalidation is based on a local evaluation of doctors' performance through appraisal. Doctors are expected to participate in annual appraisal in the workplace and must maintain a folder or portfolio of supporting information to bring to their appraisals as a basis for discussion. There will be some types of supporting information that all doctors will be expected to provide at appraisal over a revalidation cycle. However, doctors can take any other additional information to demonstrate their practice at appraisal.

Information from the appraisal is provided in Form 4 to the Responsible Officer who will make a recommendation to the GMC, every five years, on whether to revalidate a doctor. In order to revalidate a doctor, the GMC will require assurance that a doctor is fit to practise. This will be predominantly based upon the satisfactory completion of 5 annual appraisals. Multisource feedback from both patients (for those doctors who see patients as part of their medical practice), and colleagues will be required at least once during the five-year cycle. For the majority of consultants who work in NHSScotland the RO will be the Medical Director of the Health Board where they work. Generally, doctors will relate to the RO where they undertake the majority of their work.

INFORMATION

[GMC website](#)

[CEL 31 \(2012\)](#) – A Guide to Appraisal for Medical Revalidation

[CEL 31 \(2014\)](#) – amended Guide to Appraisal for Medical Revalidation

10

Appraisal

Introduction

This section summarises and supplements the guidance on the appraisal scheme for consultants in the NHS. Appraisal is a contractual requirement for all consultants and must be carried out annually. Failure to participate satisfactorily in annual appraisal can result in a decision to withhold pay progression and impact on revalidation in any year. In addition, employers are required to indicate in the distinction award review process whether a consultant has participated fully in appraisal within the last year.

A Guide to Appraisal for Medical Revalidation ([CEL 31 \(2012\)](#)) replaces all previous guidance on appraisal and as amended by [CEL 3\(2014\)](#).

Definition of appraisal

Appraisal should be a professional process of constructive dialogue, in which the consultant has a formal structured opportunity to reflect on their work and to consider how their effectiveness might be improved. This is mutually beneficial to the individual being appraised and the organisation in which they work.

Appraisal is a forward-looking process essential for the development and educational needs of an individual. It is not the primary aim of appraisal to scrutinise doctors to see if they are performing poorly but rather to help them consolidate and improve on good performance. However, it can help to recognise, at an early stage, developing poor performance or ill health, which may affect practice.

Although the appraisal may refer to the job plan, the two should be dealt with separately and the 2004 contract specifically states that these are separate processes. Time allocated for appraisal should not be spent on job plan work and vice versa. The outcome of the appraisal discussion should inform the job plan.

Appraisal process and content

Under the Medical Profession (Responsible Officers) Regulations 2010, the Responsible Officer is responsible for ensuring systems of appraisal are in place and for making recommendations on the fitness to practise of doctors within an NHS Board. The RO is thus responsible to both his/ her NHS Board as Medical Director, and to the GMC in terms of the reserved functions covered by the RO Regulations. Medical Directors as the Responsible Officer are accountable to their board for the appraisal process and must ensure that appraisers are properly trained to carry out this role and are in a position to undertake appraisal of clinical performance, service delivery and management issues.

The GMC has produced a Framework for Appraisal and Revalidation based on the document, Good Medical Practice which describes four domains and 12 attributes of good medical practice. This is the framework against which a doctor should demonstrate fitness to practise over the 5-year revalidation cycle. The Framework is available on the GMC's website (www.gmc-uk.org). The GMC's core headings are good clinical care; maintaining good medical practice; relationships with patients; working with colleagues; teaching and training; probity and health.

Who undertakes the appraisal

In secondary care, the AMD/ Clinical Director or the Appraisal Lead will select an appraiser for the doctor from the NHS Board's approved list of trained appraisers. In normal circumstances he/she/ they will be in current clinical practice and drawn from the same broad specialty as the appraisee (e.g. a surgeon by a surgeon, a laboratory doctor by a laboratory doctor); this may not be possible however for highly specialised doctors or very small specialties and is therefore NOT guaranteed.

The appraisee is entitled to request one alternate choice of appraiser. If the appraisee has legitimate reason not to accept the second appraiser then the Appraisal Lead/Advisor will appoint another trained appraiser, and that decision will be final. The guidance recognises that there are both advantages and disadvantages in having continuity of appraiser throughout the 5-year appraisal cycle and suggests it may be desirable that an appraisee should have two different appraisers during each five-year revalidation cycle.

In order that appraisal is delivered to a uniform high standard across the country, all appraisers must undertake the National Appraiser training scheme and any subsequent training. Full details are laid out in Medical Revalidation (Annual Appraisal Documentation): [CEL 31 2012](#) and as amended by [CEL 3\(2014\)](#).

The Scottish Government's guide to medical appraisal for revalidation specifies that appraisers in secondary care should undertake 10 appraisals per week and considers that 0.5 Programmed Activities (PA) is sufficient for this.

Preparation

The consultant being appraised should prepare for the appraisal by identifying those issues which they wish to raise with the appraiser and prepare an outline personal development plan. All appraisals should use the most up-to-date version of the nationally agreed appraisal documentation. The GMC has outlined the minimum supporting information that doctors will be required to bring to an appraisal. It is a requirement of appraisal for revalidation that multi source feedback is obtained from workplace colleagues (MSF) at least once every 5 years using an MSF tool which complies with GMC guidance.

Appraisees should also submit any data that is considered relevant to the appraisal. This must include sufficient relevant data relating to other work carried out external to the employer (e.g. in private practice). The information provided should address the professional roles that the doctor performs at the time of appraisal, which may differ from his/her job title, or previous specialist registration.

The information and paperwork to be used in the appraisal meeting should be shared between the appraiser and the appraisee at least two weeks in advance to allow for adequate preparation for the meeting and validation of supporting information. Preparation time and time for carrying out appraisals are not additional to consultants' other duties and responsibilities and therefore should be included in job plans.

Appraisal content

The GMC has produced a Framework for Appraisal and Revalidation based on the document Good Medical Practice. This describes four domains and 12 attributes of good medical practice. This is the framework against which a doctor should demonstrate fitness to practice over the 5-year revalidation cycle, and which should be covered in medical appraisal and on which recommendations to revalidate doctors will be based.

The framework consists of four domains which cover the spectrum of medical practice. They are:

1. Knowledge, skills and performance
2. Safety and quality
3. Communication, partnership and teamwork
4. Maintaining trust

Each domain is described by three attributes. The attributes define the scope and purpose of each domain. These attributes relate to practices or principles of the profession as a whole.

There are six types of supporting information that the GMC expects doctors to provide and discuss at appraisal at least once in each five-year cycle. They are:

1. Continuing professional development
2. Quality improvement activity
3. Significant events
4. Feedback from colleagues
5. Feedback from patients
6. Review of complaints and compliments

INFORMATION

GMC website <http://www.gmc-uk.org/doctors/revalidation.asp>

GMC website [Good medical practice framework for appraisal and revalidation](#)

Consultants should ensure that all aspects outlined above have been covered, that an opportunity has been given to raise matters of concern, and that the appraisal has not strayed from its remit.

Feedback

The GMC's requirements for patient and colleague feedback are an integral part of revalidation.

Colleague Feedback (Multi-Source Feedback MSF)

It is a requirement of appraisal for revalidation that feedback is obtained from work colleagues (MSF) at least once every five years using an MSF tool which complies with GMC guidance.

INFORMATION

A Guide to Appraisal for Medical Revalidation ([CEL 31 \(2012\)](#)) (section 6.8) and as amended by [CEL 3\(2014\)](#)

Patient Feedback

It is a requirement of appraisal for revalidation that feedback is obtained (where doctors have direct patient contact) from patients at least once every five years. It is recognised that doctors work in different environments however therefore there is not a single process for patient feedback for all doctors in NHS Scotland, and patient feedback will be undertaken locally. However, the use of the CARE questionnaire has been endorsed for both primary and secondary care.

Feedback from patients must be collected using questionnaires that comply with GMC guidance. Doctors should receive questionnaire feedback prior to the appraisal to give time for them to consider and reflect upon it. Questionnaires should be administered independently of the doctor and the appraiser. It is recommended that 25 completed patient questionnaires should be obtained in a twelve-month period.

For ease of administration it is advised that patient and colleague feedback are not generally undertaken in the same year, but ideally both should be undertaken in the first three years of the revalidation cycle.

INFORMATION

A Guide to Appraisal for Medical Revalidation ([CEL 31 \(2012\)](#)) (section 6.9) and as amended by [CEL 3\(2014\)](#)

Outcomes of appraisal

The maximum benefit from the appraisal process can only be realised where there is openness between the appraisee and appraiser. The appraisal should identify individual needs which will be addressed through the personal development plan. The plan will also provide the basis for a review with specialty teams of their working practices, resource needs and clinical governance issues. All records must be held on a secure basis and access/use must comply fully with the requirements of the Data Protection Act.

Appraisal meetings should be conducted in private, and the completed documentation will be treated as confidential. If serious issues of clinical governance or probity become apparent, then the appraiser is professionally obliged to break confidence and take appropriate action.

All appraisals should use the most up-to-date version of the nationally agreed appraisal documentation. The SOAR platform has been developed to accommodate the appraisal documentation. The appraiser and appraisee have access to all the documentation associated with the appraisal, including previous appraisals. Once the form 4/GPScot 4/PDP has been agreed and signed off by both parties the appraiser will cease to have access to this information. Where there is disagreement which cannot be resolved at the meeting, this should be recorded, and a meeting should take place in the presence of the medical director to discuss the specific points of disagreement.

The Form 4/GP Scot 4 / PDP will be sent by the appraiser to the appraisee's medical director/ clinical director (or equivalent medical line manager). The RO will have access to all Form 4s/ Scot 4s / PDPs and may require access to the full appraisal documentation in the event that a

significant concern is raised about the doctor's performance. The Appraisal Lead/Advisor will have access to all Form 4s/ Scot 4s / PDPs for the purposes of quality control of appraisal.

The Medical Director as the Responsible Officer in Scotland is accountable for ensuring that all consultants undergo an annual appraisal and that there are appropriate, trained appraisers in all cases.

The chief executive should submit an annual report on the process and operation of the appraisal scheme to the board. This information will be shared and discussed with the medical staff committee or its equivalent and the LNC. The annual report must not refer, explicitly or implicitly, to any individuals who have been appraised. The report will highlight any employer-wide issues and action arising out of the appraisal process, e.g. educational developments, service needs.

Serious concerns arising during the appraisal process

If issues arise during the appraisal process which raises serious concerns about patient safety, a doctor's practice or probity, the appraiser should stop the appraisal and take appropriate action. If after the appraisal interview the appraiser realises such issues have arisen, the appraiser is obliged to break confidence and take appropriate action. If this happens after the appraisal process has been completed (i.e. after the appraiser and appraisee have signed off Form 4/ GPSCOT4/PDP, any concerns should be addressed via the appropriate local clinical governance procedures.

If the confidence of the appraisal is to be broken, it is essential that the appraisee is aware that future action will be taken. The appraiser must report any serious concerns promptly to the Clinical Director/AMD who in turn, depending on the seriousness of the concern, would escalate to the RO.

INFORMATION

A Guide to Appraisal for Medical Revalidation ([CEL 31 \(2012\)](#)) (section 6.7 – Serious concerns during the appraisal process) and as amended by [CEL 3\(2014\)](#)

Personal development plan

As an outcome of the appraisal, the appraiser and appraisee should review progress against last year's personal development plan and identify key development objectives for the year ahead, which relate to the appraisee's personal and / or professional development. This will include agreed actions

The actions agreed in the Form 4/GPScot4/PDP are for the appraiser to pursue, and the appraiser has no ongoing responsibility to ensure that actions are followed, or resources made available. For consultants that responsibility lies with the medical manager.

Consultants working in more than one board

Employers must agree on a 'lead' employer for the appraisal. Agreement will also include appropriate discussion prior to the appraisal to ensure key issues are considered, systems for accessing and sharing data; and arrangements for action arising out of the appraisal.

Consultants with honorary university contracts

As recommended by the Follett report, NHS consultants with a substantial role in undergraduate teaching, administrative work or university-led research under an honorary contract with a university should undergo joint appraisal in respect of their complete range of NHS and university duties (either with one appraiser for each component, or a single joint appraiser if properly qualified for this task). As part of the appraisal process, there is a supplementary appraisal form specifically to allow doctors to present information relating to the academic component of their work, which is available in electronic form on the SOAR platform.

INFORMATION

GMC [Continuing Professional Development for Doctors](#) GMC [Supporting Information for Appraisal and Revalidation](#) GMC [Guidance on Colleague and Patient Feedback](#) [SOAR website](#) for secondary care doctors

11

Consultant reward schemes

The distinction awards process in Scotland has been frozen since 2010. This freeze was initially imposed as an interim measure pending the publication of the DDRB report into award schemes. SCC has continued to call upon the Scottish Government to reinstate higher awards in Scotland as a priority, until an appropriate Scottish way forward has been agreed.

The advice which follows is based on the current scheme and documentation.

INFORMATION

[SACDA \(Scottish Advisory Committee on Distinction Awards\) website](#)

Discretionary points

The consultants' discretionary points scheme was introduced in April 1996, replacing the old C award element of the distinction awards scheme. All consultants who have reached point five of the pay point scale are eligible for consideration. Distinction award holders are ineligible. Consultants granted discretionary points are not normally considered again for two years, although employers and the LNCs locally may vary this provision.

The following principles also apply:

- there are no age limits for discretionary points
- locum consultants are not eligible for the payment of points
- clinical academics with honorary consultant contracts are eligible for payment of points and should be considered equally with other consultants
- consultants working for other employers on a service agreement or recharge basis are considered for points by the employer holding the contract, but consultation should take place with the employer providing the service
- consultants jointly contracted to more than one employer (i.e., where there is one contract) are considered under the arrangements agreed between the employers for determining pay and conditions of service matters or any agreed lead employer responsibilities
- consultants employed under separate contracts (i.e., where there is more than one contract) are considered by each employer under each contract.

Salary

Discretionary points are consolidated payments in addition to the consultant's salary and there are eight points of equal value. Points are paid at the discretion of the employer in the light of advice from the profession locally (subject to the award of a minimum number of points – see below). Discretionary points are pensionable, and consultants will retain payment of points granted by one NHS employer on transfer to another NHS employer. Awards for each round are paid from 1 April.

Numbers of points

Employers are required to award a minimum of 0.35 points per eligible consultant per year. This is a minimum number and employers may award more. More than one discretionary point at a time may be awarded to individual consultants.

When employers calculate the number of points they are required to award, if a fraction of a point results, this should be rounded up to a whole point. Therefore, individual consultants should only receive whole points and not fractions of points. Where a small number of consultants is employed, employers may be flexible, for example, by aggregating points over two years.

The calculation of the number of eligible consultants is made on the basis of actual numbers rather than whole-time equivalents.

Criteria

The principles of the nationally agreed criteria are:

- discretionary points are not seniority payments, nor automatic annual increments
- consultants in all specialties and all types of posts are equally eligible
- to warrant payments, consultants are expected to demonstrate an above average contribution in respect of service to patients, teaching, research and the management and development of the service.

Contributions to clinical audit, professional and multidisciplinary team working and wider contributions to the work of the NHS nationally should also be considered. Significant contribution towards the achievement of local NHS service priorities, and undertaking recognised significant heavy workload or responsibilities in pursuit of local NHS service goals, are also to be taken into account

- progression at each step up the discretionary points scale should reflect an increasing quality and range of contributions
- Less than full time consultants are paid the appropriate proportion of the value of any points awarded

There is no nationally agreed procedure for determining how applications for discretionary points should be made and arrangements may vary from employer to employer. Most employers have a procedure agreed with the LNC.

There is also no nationally agreed mechanism for making decisions about who should receive discretionary points. Boards have agreed procedures with the LNC.

Appeals

There is no nationally agreed model for an appeals mechanism, but employers should have in place a mechanism for appeals about the operation of the system.

INFORMATION

SEHD Letter to chief executives regarding changes to the discretionary points system, 12 January 2000 (available via the BMA [website](#))

[NHS Circular PCS \(DD\) 1995/6](#) Consultants' Discretionary Points

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Disciplinary procedures and suspension

Consultants facing disciplinary action are advised to seek help from the BMA at the earliest opportunity.

NHS boards, as employers, carry responsibility for investigations into allegations against any of their medical or dental staff and for any subsequent disciplinary processes. They are also responsible for implementing the Once for Scotland disciplinary procedure for medical and dental staff regarding personal conduct. In respect of all other aspects of disciplinary procedures, employers must follow the provisions in the relevant NHS circulars issued by the SGHSCD.

Disciplinary procedures cover the following areas:

- personal misconduct
- less serious cases of professional misconduct or incompetence – an intermediate procedure
- serious cases of professional misconduct or incompetence
- appeals, including the right to appeal to Scottish ministers under paragraph 190 for eligible consultants (see below) and the right for a consultant to appeal against the employer's decision concerning whether a complaint or allegation relates to personal or professional issues.

The definitions to classify conduct are contained in [NHS Circular 1990 \(PCS\) 8](#) and are as follows.

Personal conduct: performance or behaviour of practitioners not associated with the exercise of medical or dental skills.

Professional conduct: performance or behaviour of practitioners arising from the exercise of their medical or dental skills.

Professional competence: adequacy of performance of practitioners arising related to the exercise of their medical or dental skills and professional judgement.

The procedures set out in the national guidance are covered in the following sections.

Personal misconduct

In cases solely involving personal misconduct, the position of a doctor or dentist is no different from that of any other health service staff. Employers should draw up detailed disciplinary procedures covering all their staff that provide mechanisms for investigating alleged offences, disciplinary hearings, a series of warnings short of dismissal, dismissal itself and appeals against formal action. Employers must follow the Once for Scotland process for [Conduct Policy](#).

There is an agreed appeal mechanism if a doctor or dentist does not agree with the employer's decision to treat an allegation as one of personal conduct. The doctor/dentist may [appeal](#) within seven days of receipt of the formal notification to a Classification Appeal Committee, which is constituted as follows:

- a chairperson, drawn from an agreed list, who will be a solicitor and not in the employment of the NHS or the Central Legal Office
- a medical director/DPH from another board
- a medically/dentally (as appropriate) qualified professional not employed by the board nominated by the BMA LNC.

The decision reached on the classification is binding on both parties.

Consultants who have the right to an appeal against dismissal to Scottish ministers under paragraph 190 should be aware that this right does not apply to cases of personal misconduct.

INFORMATION

[NHS Circular PCS \(DD\) 2001/9](#): Discipline procedures – classification of conduct
[NHS Circular 1990 \(PCS\) 8](#) as amended by [1990 \(PCS\) 32](#) Disciplinary procedures for hospital medical and dental staff and doctors in public health medicine and community health
 NHS Scotland Workforce Policies: [Conduct](#)

Intermediate procedure

Employers should follow the process identified in Annex B of the NHS Circular 1990 (PCS) 8 to resolve cases of alleged professional misconduct or incompetence where the outcome will fall short of dismissal. Under NHS Circular 1990 (PCS) 8, such a procedure involves an investigation by external clinical assessors. It provides a mechanism to deal with problems at an early stage and could be used either for specific disciplinary allegations or for problems arising from differing professional views within a department.

Role of the clinical assessors

The medical director is responsible for requesting the appointment of external assessors. Under the nationally agreed procedures, these are nominated by the Scottish Academy. The assessors will visit the employer, investigate the problem (including interviewing those involved) and report to the medical director. They may claim expenses in respect of the visit.

Rights of the consultant

The consultant should be provided with a list of those to be interviewed, given the opportunity to ask for other individuals to be interviewed, provided with copies of written statements and should be able to be accompanied by a colleague or representative when interviewed.

Assessors' report

The assessors are asked to provide a report setting out the findings and facts and making recommendations for action. The consultant should be able to comment on the factual content.

Disciplinary action

The medical director will need to decide what, if any, further action is required, which may include periods of retraining, study, or mentoring as well as disciplinary hearing. The employer will have to set up a panel as a result of the report if disciplinary action is a possible outcome.

Appeals

The consultant must have the opportunity to appeal. Since these cases involve matters of professional conduct or competence, the appeal panel should have independent medical representation.

Consultants facing a professional misconduct or incompetence procedure should take urgent steps to secure representation from their medical defence organisation.

Serious cases of professional misconduct or incompetence

This type of procedure should be used for handling serious disciplinary matters of a professional nature when the outcome could be dismissal. The procedure involves a panel inquiry where, because of the potentially serious outcome, evidence is likely to be legally tested. The steps below should be followed by the employer in line with Annex C.

Preliminary investigation

The medical director should carry out a preliminary inquiry to establish if there is a prima facie case, which could result in serious disciplinary action.

Doctor informed

The doctor should be informed immediately of the nature of the complaint and be given the opportunity to comment on the case before a decision is taken to proceed.

Decision to proceed

If the decision is to proceed, an investigatory panel will need to be set up to conduct the inquiry. If the facts have already been established in a court of law, there is no need for an inquiry.

The findings of a government public inquiry may also be sufficient to mean that a further investigation is unnecessary.

Inquiry

The employer should set up a small panel which in most cases will be chaired by a lawyer. There should also be independent professional input. The Scottish Academy is used as a source of advice for choosing professional members as provided under NHS Circular 1990 (PCS) 8. The hearing should be held in private and take the form of a formal examination of the witnesses.

Panel report

The panel report should be in two parts: the factual part and the part containing the panel's views on whether the doctor was at fault. The second part may also contain recommendations for disciplinary action. The doctor should have the opportunity to comment on the factual content of the report. The doctor can have legal representation at any disciplinary hearing.

NHS board's decision

The NHS board should be responsible for determining the need for any further action. The doctor should be informed of the recommendations and be given the opportunity to offer any mitigation.

Time limits

The employer should have time limits in operation for each stage of the case. As provided in NHS Circular 1990 (PCS) 8 the procedure should be completed within 32 weeks.

Appeals

There should be a mechanism for appeals against the decision of the NHS board, whether that decision is dismissal or less serious action. In addition, consultants with protected paragraph 190 appeal rights are eligible to appeal against dismissal to Scottish ministers under paragraph 190 of the TCS (see below).

For non-paragraph 190 appeals, the SCC advises that the employer should set up an appeal panel, normally with a legal chairperson. The NHS board should provide a member of the appeal panel, for example, the board chair or another non-executive director. If a member of the NHS board is on the appeal panel, it is important that they should have been excluded when the board made its original decision on disciplinary action. There should also be external consultant input nominated by the LNC and agreeable to the employer.

Paragraph 190 appeals

A consultant appointed prior to 1 April 2004, and whose contract included a right of appeal against dismissal to Scottish ministers under the provisions of paragraph 190 of the pre-2004 contract, continues to benefit from this right of appeal. Other consultants have the right of appeal against dismissal as locally agreed between the employer and the LNC.

INFORMATION

TCS, section 10 and appendix 9

[NHS Circular No 1990 \(PCS\) 8](#) as amended by [1990 \(PCS\) 32](#)

Suspension

Occasionally, employers may find it necessary to suspend a consultant from duty in order to assist the process of investigation and/or to protect the interests of patients, the consultant and other staff. In order that clear procedures can be set up locally, employers should take into account the guidance on suspension contained in [NHS circular PCS \(DD\) 1994/11](#). The guidance includes an indicative timescale. Where suspension is considered, the following principles should apply:

- the employer is required to give serious consideration to alternatives to suspension and it is important to ensure that this has been done
- suspension should not be seen as a punitive measure and is without prejudice to subsequent inquiries
- suspension should always be on full pay
- periods of suspension should be kept as short as possible, and every effort made towards early resolution of the case. A review of the position should take place regularly (the circular recommends review on a fortnightly basis), and the consultant kept informed of developments after each review.

As a result of a report from a working group on suspension of medical and dental staff in 1999, [PCS \(DD\) 1999/7](#) additional guidance was developed for employers which includes the following points:

- employers are required to notify the SGHSCD of any suspensions and provide monthly progress reports as well as a final report reviewing the process
- a pool of legally qualified chairs and lay members has been established from which employers can draw to sit on Committees of Inquiry
- dates and timescales for the procedure should be laid down at the preliminary hearing
- NHS boards with honorary contract holders on their staff should have agreed arrangements with the university, as the substantive employer, for disciplining such individuals
- control should be exercised over suspended doctors or dentists working as locums.

INFORMATION

[NHS Circular PCS \(DD\) 1994/11](#) – Disciplinary Procedures for Hospital Medical and Dental and Community Medical Staff

[PCS \(DD\) 1999/7](#) – Report of the Short Life Working Group on Suspension of Medical and Dental Staff

13

Consultant appointment procedures

Consultants carry ultimate clinical responsibility for every patient seen under their care. The public is therefore entitled to expect that all consultants will have reached the highest standards of skill and knowledge, and the appointment of consultants is regulated by means of a statutory appointments procedure. The regulations and supporting guidance for consultant appointments were revised in July 2009 ([The National Health Service \(Appointment of Consultants\) \(Scotland\) Regulations 2009](#)).

While the majority of the actions within the consultant recruitment process, which were previously subject to regulation, now lie with the NHS boards who hold responsibility for the process, some key elements are still subject to regulation and remain under statutory control. The statutory element includes the appointment of a trained External Adviser from a different NHS board as a full member of the consultant assessment panel: this is intended to ensure the clinical quality of appointed candidates is maintained. The External Adviser will have been trained in selection processes and, with experience of other appointments, can provide advice on the appointment from a different perspective than the local clinical team.

Planning and advertising a consultant post

Employers should begin planning for a consultant appointment well before the post is to be filled. They should consider service needs, the amount and level of training that may be required, teaching, supervision of junior staff, continuing professional development, research and any special interests and produce a draft job description and person specification which must be sent to the External Adviser for their advice and comment. They should also identify a lead officer to manage each individual recruitment process.

All potential applicants should be given the job description; the person specification; information from the board with details of arrangements for practice, e.g. units, clinics etc; details of staffing and relevant services covered; where appropriate, information about undergraduate or postgraduate medical/dental teaching; and the relevant TCS including pay. The employer should also ensure that a job plan is available for the consideration of candidates for appointment to a consultant post.

Employers should look to advertise details of vacant posts widely. The use of the SHoW (Scotland's Health on the Web) vacancy database is strongly encouraged: it is available online at: <http://www.jobs.scot.nhs.uk/>

Candidates for consultant posts should always request details of the TCS from the board in advance of the appointments committee. Advice can also be sought from the BMA, and from the LNC.

Eligibility for appointment and specialist register

On successful completion of specialty training, doctors are awarded a certificate of completion of training (CCT (Certificate of Completion of Training)), allowing them to practise across Europe as recognised 'specialists'. The GMC recommends CCT holders for inclusion on the specialist register, which it administers. The specialist register includes the names of all CCT holders together with those of other eligible specialists, and shows their specialty and, if requested, any particular field of expertise within it. Eligible specialists are defined as:

- European Economic Area nationals holding recognised specialist qualifications
- other overseas nationals holding specialist qualifications that are deemed equivalent to the CCT
- doctors who have followed academic or research training paths, resulting in a level of knowledge and skill consistent with NHS consultant practice in that specialty.

INFORMATION

General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 EC Medical Directive 93/16/EEC

The European Specialist Medical Qualifications Order, Statutory Instrument 1995 No 3208

GMC: http://www.gmc-uk.org/doctors/before_you_apply/background.asp

From 1 January 1997 it has been a legal requirement for all doctors to be on the GMC's specialist register before they can take up a consultant appointment. (In the case of consultant dental posts, individuals must be a registered dental practitioner or a fully registered medical practitioner). However, trainees may explore the possibility of post-CCT careers as soon as it is apparent that a CCT will be awarded in the near future. Consequently, SpRs/StRs are able to apply for a consultant appointment provided the expected date of award of their CCT (or recognised equivalent, if outside the UK) falls no more than six months after the date of interview for the consultant post. The consultant assessment panel must also be satisfied that the applicant is sufficiently near to the completion of training to enable them to judge the applicant's suitability for a consultant post.

Membership of the assessment panel

The assessment panel is convened by the appointing board to conduct the candidate assessment. This assessment may include profiling, aptitude tests or multi-station interviews. The panel must include at least one consultant from the specialty. Where possible that consultant should be from the employing board. Depending on the nature of the post and the extent of any undergraduate teaching or training duties, the board may include university representation on the assessment panel. While there is no set limit on the size of the panel, under the regulations the panel must as a minimum include a Chair, with delegated authority from the Board, an External Adviser and one other consultant from the specialty.

External Adviser

The regulations require that a single External Adviser is included on the assessment panel for consultant appointments within the NHS in Scotland. The role of the External Adviser is to advise the recruiting board on each stage in the process, including commenting and advising on the job description, person specification, the selection methodology and participating in the selection process. This External Adviser is identified from the list of External Advisers maintained by the Academy of Royal Colleges and Faculties in Scotland and must be external i.e. not employed by the recruiting board and must be in the same specialty as the post being appointed to. In rare instances of small specialties it may be necessary to seek an External Adviser from outside Scotland.

All newly appointed External Advisers undergo training before they are included on the adviser list, and if reappointed to the list again, should undergo refresher training.

This training is co-ordinated by NHS Education for Scotland and includes: detailed training on equality and diversity issues;

- refreshers on specialty training curricula and assessment methods used;
- updates on selection methodology and tools that have been used successfully;
- the option to shadow an External Adviser and observe the process, although it should be emphasised that observers will play no role in the recruitment process.

Process

Under the regulations, recruiting boards will appoint a Chair for the assessment panel. The Chair will hold delegated authority to offer the post on behalf of the board once the panel has considered the candidates.

Boards should draw up a policy on the use of visits as part of the employment process and communicate this policy to all applicants. Visits are intended to inform the applicant regarding the department and the requirements of the post. Depending on the nature of the post the policy on visits should look to offer applicants an opportunity to visit the department and meet with key staff. The option of a visit, and the timing of such a visit, should be determined by the board, and should be made available to all applicants at the same point in the recruitment process.

Once the assessment panel has made a decision on which candidate(s), if any, should be offered the post, the Chair and the HR Department will then take responsibility for offering and contracting with successful candidates. Any candidate wishing to appeal a decision made by the panel should do so through the appointing board.

All members of the assessment panel hold equal responsibility for raising concerns at any stage within the recruitment process with the Chair. In these instances, it is for the Chair to assess these concerns and to determine whether or not to proceed with the recruitment process. If the decision is taken to proceed to appointment, the Chair should note the concerns raised and indicate the basis on which the decision to proceed was taken. If the Chair decides not to proceed, this decision is reported back to the board, outlining the basis on which this decision was taken. It is for the board to decide on next steps and whether to re-run the process.

If any member of the assessment panel has concerns about the appointment made or the conduct of the appointment, they should make their concerns known in writing to the Chair of the recruiting board, and if it is the External Adviser who has concerns, these should also be made known in writing to the Scottish Academy.

Fees and expenses

Applicants: Doctors who are currently employed under the national TCS (e.g. consultants or SpRs/StRs seeking a first consultant appointment) are entitled to have their expenses reimbursed by the prospective employer at the appropriate rate. This may include pre-interview visits, providing the applicant is subsequently shortlisted.

Members of assessment panels: External Advisers are entitled to a fee and travelling expenses. Consultants are only entitled to a fee if the AAC duty is undertaken outwith agreed PAs.

INFORMATION

[CEL 25 \(2009\)](#) The NHS (Appointment of Consultants (Scotland) Regulations 2009 TCS, paragraphs 3.1.5, 9.6 and appendix 5 (b)

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Private and independent practice

This section sets out the position relating to private practice under national TCS and other national agreements.

Definition of private practice

Private practice is defined for consultants in the TCS as 'the diagnosis or treatment of patients by private arrangement'. A private patient is defined in the NHS Acts as a patient who gives (or for whom is given) an undertaking to pay charges for accommodation and services.

Code of conduct on private practice

A code of conduct for private practice setting out recommended standards for NHS consultants is included in the TCS. Its aim is to minimise the risk of a conflict of interest arising between a consultant's private practice and NHS commitments. The code states that consultants should conform to any local policies and procedures for private practice. Consultants are, therefore, advised to contact their LNC for advice on any local arrangements that may apply.

Disclosure of information

The code says that consultants should disclose details of regular private practice commitments, including timing, location and broad type of activity, as part of the job planning process.

Scheduling of work

Programmed NHS commitments should take precedence over private work and private commitments should not be scheduled during times that a consultant is scheduled to be working for the NHS. Private commitments should be rearranged if there is regular disruption to NHS work and private work should not stop a consultant from being able to attend NHS emergencies when on call. However, the code recognises that there will be circumstances when a consultant may need to provide emergency private care when working for the NHS.

INFORMATION

TCS, appendix 8: Code of Conduct for Private Practice: Recommended Standards for NHS Consultants

[PCS \(DD\) 2009/1](#) Changes to consultant contract code of conduct on private practice

[BMA members guidance: Setting up in private practice](#)

15 NHS contractual provisions

NHS work and private practice

In addition to the code of conduct, the TCS also contain contractual provisions dealing with the relationship between NHS and private activity. These state that consultants are free to undertake private practice without requiring the approval of their employer and without impact on their NHS contract, provided that such work is undertaken outside the time agreed in the job plan for NHS work. In addition, consultants undertaking private practice are obliged to inform their employer in writing.

INFORMATION

TCS, section 6

Extra PAs and pay progression

Under the contract, there is no obligation for consultants to undertake PAs in excess of the standard 10 per week if they want to do private practice as a full-time consultant. However, one of the criteria for remaining eligible for pay progression is that consultants should accept up to one extra paid PA in the NHS, if offered, before doing private work. The following points should be noted:

- if consultants are already working 11PAs, there is no requirement to undertake any more work. 11 PAs could be fewer than 44 hours if some work is undertaken in premium time
- a consultant could decline an offer of an extra PA and still work privately, but with risk to NHS pay progression for that year and any extra PAs must be offered equitably between all consultants in that specialty.

Where a consultant intends to work privately, the matter should be discussed with the employer. The employer may then offer the consultant the option of undertaking up to one extra paid PA per week. The consultant may choose either to accept or reject the offer. If rejected, the employer is entitled to withhold pay progression for that year only.

Where possible, the offer of extra PAs should be made at the annual job plan review and should be no less than three months in advance of the start of the proposed extra PAs, or no less than six months in advance where the consultant would need to reschedule external commitments. There is a three-month minimum notice period for termination of the extra PAs on both sides.

INFORMATION

TCS, section 6 and paragraphs 4.4.6-4.4.12

Private practice during sick leave

Consultants should be extremely cautious during sick leave with regard to the other activities they normally carry out. Most employers may regard the undertaking of private practice as a serious disciplinary offence. Consultants should always check with their employer and get confirmation in writing before undertaking work while on sick leave and should seek advice from the BMA.

INFORMATION

Sections 57 and 58 of the NHS (Scotland) Act 1978 (as amended) Schedule 9 of the NHS and Community Care Act 1990
 Management of Private Practice in Health Service Hospitals in Scotland 1987 (The Green Book)
 Health and Medicines Act 1988
[CEL 09 \(2010\)](#) – Overseas visitors' liability to pay charges for NHS care and services
 BMA members guidance: Private practice and junior doctors TCS Appendix 8: Code of Conduct for Private Practice: Recommended standards of practice for NHS Consultants
[SGHSCD/CMO \(2009\) 3](#) Arrangements for NHS patients receiving healthcare services through private healthcare arrangements

Medical indemnity and private work

Consultants should note that the NHS indemnity scheme does not cover private work, either in the NHS or in private hospitals. Consultants should ensure that they have appropriate indemnity with a medical defence body to cover them for private practice. Indemnity for private prescribing will depend on the individual circumstances. Consultants should seek advice from their medical defence organisation.

Appropriate cover can be obtained from one of the following organisations:

[Medical Defence Union](#)

[Medical and Dental Defence Union of Scotland](#) [Medical Protection Society](#)

GMC position on financial and commercial dealings

INFORMATION

GMC Good Medical Practice

Fee-paying work

The arrangements under which NHS consultants may carry out fee-paying work under the 2004 contract, such as reports for insurance companies and medico-legal work, are covered in the section on pay. The BMA has limited opportunities to recommend fees for such work undertaken by consultants. However, certain organisations set fees for such work and the BMA has also been able to agree fees with other organisations, such as some government departments. These are set out in the BMA's fees guidance schedules available from the BMA or via the BMA website.

INFORMATION

[BMA Members fee guidance](#)

Medico-legal work

Medico-legal work is perhaps the most complex area of fee-paying work. Consultants are generally approached to provide medical reports in connection with a legal action and/or attend court to give evidence, which may involve conferences with counsel or other related work.

Medico-legal work counts as fee paying work under the contract and is distinct from private practice. The fees which may be paid will depend on the status of the witness, i.e. whether the consultant is a witness to fact, a professional witness, or an expert witness. There is also a distinction between criminal and civil proceedings. It is important for consultants asked to undertake medico-legal work to be aware of these distinctions and also to agree in writing in advance the nature of the work to be undertaken, the fees for that work (including cancellation fees), and any further commitments that may arise.

INFORMATION

[BMA Fees Guidance Schedule on medico-legal fees in Scotland](#) [BMA Members Expert Witness Guidance](#)

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Pensions

Occupational pension schemes

The NHS pension scheme is a statutory scheme, meaning that the rules which govern the scheme are set out by the Government in primary legislation. The scheme is also subject to legislation issued by HM Revenue and Customs. The BMA has a factsheet online providing a broad outline of the scheme. The scheme rules are complicated and frequently change. Where members are uncertain or when urgent decisions have to be made, please [seek advice from the BMA Pensions Department](#).

INFORMATION

Planning for retirement: <https://www.bma.org.uk/advice/employment/pensions>

NHS Pension

Pensions are a complex and changing issue for doctors. Detailed guidance on the NHSPS can be found on the pension pages of the BMA website giving information on UK doctors' pensions issues, including the different sections of the NHS pension scheme, contributions, annual allowance and tax: <https://www.bma.org.uk/advice/employment/pensions>

There are regular updates from SCC office bearers on Scottish specific pension issues on the BMA Scotland webpages: <https://bmascotland.home.blog/tag/pensions/>

INFORMATION

[BMA Members pensions webpages](#) [Blogs from SCC office bearers](#)
[BMA Members pensions factsheet](#)

Clinical and medical directors

The pension position will depend upon the terms of the medical or clinical director's contract. If the contract involves extra PAs beyond full time, these will not be pensionable. If the substantive contract is (LTFT) less than full time (less than 10 PAs), then the extra PAs will be pensionable up to 10 PAs in total. The medical/clinical director PAs will also be pensionable if they simply replace pensionable clinical PAs. If the contract provides for extra salary to take account of medical/clinical director responsibilities, over and above the full-time 10PAs then it is important to check if this pensionable or not as this can have significant tax implications.

[BMA Members pensions webpages](#)
[BMA Members pensions: medical/clinical directors' information](#)

Working in the NHS after retirement

It is not normally possible to re-join the amended NHSPS on returning to work after retirement. A break in service needs to be taken before returning to work in the NHS. Consultants who retire at the normal retirement age or who take voluntary early retirement with actuarial reduction or who have used their redundancy payment to fund their accrued benefits will not be subject to any reduction of NHS pension (also known as abatement) on return to work in the NHS.

For consultants retiring on health grounds and returning to NHS employment there is the possibility that some of their pension may be reduced depending on the level of post-retirement NHS earnings and the tier to which they had been allocated.

INFORMATION

[BMA Members Planning for Retirement:](#)

Personal pension plans (PPPs)

Consultants in the amended NHSPS can take out a PPP. Additionally, if the consultant returns to work after retirement, the NHS income is not pensionable in the amended NHSPS and can therefore be pensioned in a PPP.

Further advice

The Scottish Public Pensions Agency (<http://www.sppa.gov.uk/>) can provide estimates of benefits in advance of retirement and answer enquires about the NHSPS (the address and phone number are in all BMA pension factsheets). Guidance can also be obtained from the BMA website and the BMA pensions department.

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Redundancy

The Scottish Government currently has a no compulsory redundancy position across NHS Scotland. For any issues relating to redundancy, call a BMA adviser on 0300 123 1233 or email your query.

Organisational change protections

An organisational change policy statement agreed by the Scottish Partnership Forum covers all organisational change in the NHS in Scotland and offers useful protections for staff. It covers issues such as the avoidance of compulsory redundancy, consultation and communication with trade unions and professional organisations, no detriment to current TCS (including income and earnings levels), preservation of pension benefits and premature retirement.

INFORMATION

BMA website: <https://www.bma.org.uk/advice/employment/redundancy>

PIN guideline: <https://www.gov.scot/publications/redeployment-partnership-information-network-pin-policy/>

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European Working Time Directive (EWTD)

All employed doctors are covered by the European Working Time Directive (EWTD), which is legislation designed to protect employees from working excessive hours. For more information see: <https://www.bma.org.uk/advice/employment/working-hours>

Compensatory rest

The Directive allows employers to exclude the provisions in relation to length of night work, daily rest, weekly rest and rest breaks if compensatory rest is provided. This means that where rest is delayed or interrupted by work, compensatory rest must be granted. However, there is flexibility about how and when compensatory rest is calculated. The entitlement to compensatory rest will be granted by the employer 'wherever possible' (Regulation 24, Working Time Regulations 1998).

The BMA's view is that rest should be taken within a reasonable period and before returning to work. The Jaeger judgment in the European Court of Justice examined the provision of compensatory rest and stated that: 'equivalent periods of compensatory rest made up of a number of consecutive hours corresponding to the reduction applied and from which the worker must benefit before commencing the following period of work'.

The BMA recommends that local agreements recognise the importance of ensuring rest is taken as soon as possible after a disruption to rest. It is good practice for such compensatory rest to be taken immediately after the end of the working period. A doctor may commence work at a later time on the day following a significant interruption to rest, after notifying the responsible manager where work was to be performed. Any consultant having to take compensatory leave should ensure that colleagues are forewarned in order that appropriate cover arrangements can be arranged if necessary.

The length of the rest period that should be taken is not clearly defined in the directive. In each situation the rest provided should make up for the rest missed; and, under the provisions of the Jaeger ruling, should be taken immediately after the end of the working period. The implications of the Jaeger ruling are that it will not be sufficient to aggregate the rest available to an individual over a period and assume that the minimum requirements have thus been met.

Doctors on less than full-time contracts are entitled to the same compensatory rest breaks as those doctors on full-time contracts. It is therefore essential that doctors monitor their hours worked and their entitlements to compensatory rest.

The Directive is not aimed at providing extra periods of leave that consultants can accumulate over a period of time; it aims to ensure consultants are not tired when working.

19 Doctors in management

Introduction

The GMC's Leadership and management for all doctors sets out the wider management and leadership responsibilities of all doctors in the workplace, including:

- responsibilities relating to employment issues
- teaching and training
- planning, using and managing resources
- raising and acting on concerns
- helping to develop and improve services.

Consultants are expected to play their part in managing their organisations, not least to ensure that medical issues are given proper priority in the employer's decision-making process. Most NHS boards have established a framework of operating divisions with a divisional/associate medical director and a structure of clinical directorates.

The BMA supports medical managers via the [Committee of Medical Managers](#).

Pay

Medical managers can be rewarded in a variety of ways for their management work. Board medical directors have nationally agreed pay and conditions of service while clinical directors may be rewarded by PAs (substituting management duties for other work), EPAs or additional responsibility payments.

Guidance on pensions for clinical and medical directors can be found in the Pensions section.

Medical directors

The [Committee of Medical Managers](#) has produced guidance on the role of medical directors. The guidance is on the website: <https://bma.org.uk/practical-support-at-work/doctors-as-managers/medical-managers>

INFORMATION

BMA Guidance <https://bma.org.uk/practical-support-at-work/doctors-as-managers/medical-managers>

[PCS \(MD\) 2008/1](#): pay and conditions of service for health board medical directors (including model contract)

[GMC Guidance Management for Doctors](#)

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Acronyms

ACAS	Advisory Conciliation and Arbitration Service
ACC	Area Consultants Committee
AVC	Additional Voluntary Contribution
CC	Consultants Committee
CCT	Certificate of Completion of Training
CEL	Chief Executive Letter
CHP	Community Health Partnership
CMO	Chief Medical Officer
CNORIS	Clinical Negligence and Other Risks Indemnity Scheme
CPD	Continuing Professional Development
CPHM	Consultant in Public Health Medicine
DA	Distinction Award
DCC	Direct Clinical Care
DDRB	Doctors and Dentists Review Body
DH	Department of Health
DP	Discretionary Point
DPH	Director of Public Health
EC	European Commission
EPA	Extra Programmed Activity
EPP	Exposure Prone Procedure
EWTD	European Working Time Directive
FSAVC	Free Standing Additional Voluntary Contribution
GDC	General Dental Council
GMC	General Medical Council
GP	General Practitioner
GWC	General Whitley Council
HAI	Healthcare Associated Infection
HIV	Human Immunodeficiency Virus
HMRC	HM Revenue and Customs
HSE	Health and Safety Executive
JNC(S)	Joint Negotiating Committee (Seniors)
LNC	Local Negotiating Committee
MAC	Medical Advisory Committee
MCN	Managed Clinical Network
MHO	Mental Health Officer
MRC	Medical Research Council
MSC	Medical Staff Committee
NHS	National Health Service
NHSPS	National Health Service Pension Scheme
PA	Programmed Activity
PCS	Pay and Conditions of Service Circular
PIN	Partnership Information Network
PPP	Personal Pension Plan
SACDA	Scottish Advisory Committee on Distinction Awards
SAS	Staff and Associate Specialist Grades
SGHSCD	Scottish Government Health & Social Care Directorates
SCC	Scottish Consultants Committee
SPA	Supporting Professional Activity
SPPA	Scottish Public Pensions Agency
SpR	Specialist Registrar
StR	Specialty Registrar
TCS	Terms and Conditions of Service
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981



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Free and confidential 24/7 counselling and peer support services open to all doctors and medical students on **0330 123 1245**.

In addition to our existing telephone/video counselling, for a limited time only you can also access face-to-face counselling sessions. All counsellors are members of the BACP and bound by strict codes of confidentiality.

Wellbeing support services

COUNSELLING | ONLINE | PHONE | FACE TO FACE
0330 123 1245 | bma.org.uk/yourwellbeing

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bma.org.uk

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